Crosswalk between Public Health Accreditation Board's Standards and Measures and CDC's Public Health Emergency Preparedness and Response Capabilities

Introduction

The Centers for Disease Control and Prevention's (CDC) Center for Preparedness and Response (CPR) and Center for State, Tribal, Local and Territorial Support (CSTLTS) collaborated to develop a crosswalk that highlights potential linkages between CDC's public health preparedness and response capabilities and the population-based accreditation standards and measures for health departments established by the Public Health Accreditation Board (PHAB). The crosswalk can help health department preparedness and accreditation staff demonstrate specific examples of preparedness activities that help fulfill accreditation objectives and strengthen crosscutting health department performance improvement efforts.

This document illustrates the alignment between:

- PHAB's *Standards and Measures*[1] version 1.5 for voluntary accreditation of state, tribal, local, and territorial public health departments.

- CDC's 2018 *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health*.[2]

Both sets of standards were initially released at approximately the same time (2010-11), were developed, or supported by CDC, and have continued to evolve. The preparedness and response capability standards and the accreditation standards are designed to advance the quality, performance, infrastructure, and effectiveness of public health departments. However, each serves a unique purpose.

The Public Health Accreditation Standards and Public Health Emergency Preparedness and Response Capabilities Crosswalk (Accreditation and Preparedness Crosswalk) is intended to assist public health department leaders, public health emergency preparedness program directors, and accreditation coordinators in recognizing areas where preparedness activities, procedures, and documentation might support PHAB accreditation efforts. Likewise, PHAB accreditation and quality improvement efforts may contribute to strengthening the capacity of public health departments to prepare for and respond to public health threats and emergencies.

The Accreditation and Preparedness Crosswalk is not intended to provide all definitive linkages between PHAB standards and measures and public health preparedness and response capability standards. Nor is it a guarantee of conformity to PHAB documentation requirements. Rather, the crosswalk is intended to support health department leaders, preparedness directors, accreditation and performance coordinators, and other program staff in recognizing important areas of connection.

Background

Public Health Accreditation for Health Departments

PHAB is a nonprofit organization established in 2007, with funding from CDC and the Robert Wood Johnson Foundation, to advance public health performance. PHAB oversees the voluntary national accreditation program for public health departments. The program's goal is to improve and protect the public's health by advancing the quality and performance of state, local, tribal, and territorial public health departments.

The program was formally launched in 2011 after several years of field-driven development and testing. The first health departments were accredited in 2013, and, as of July 2020, 82% of the U.S. population is served by an accredited health department.

National public health department accreditation was developed to improve service, value, and accountability to stakeholders. Accreditation can play an important role in standardizing public health practice, strengthening quality and performance, and driving change. PHAB accredits public health departments based on their conformity with an established set of standards. The PHAB Accreditation Standards are constructed on a framework of 12 domains, the first 10 of which are based on the *10 Essential Public Health Services*.[3] The domains and their associated standards and measures are intended to include the categorical work of a public health department but are not intended to be program specific. In 2011, PHAB released Version 1.0 of the *Standards and Measures;*[4] these were updated in 2014 through Version 1.5. Most recently, PHAB released reaccreditation requirements.[5]

PHAB accreditation is awarded for a period of five years. During those five years, public health departments must submit annual reports describing how they are addressing priority areas for improvement. The requirements and process for reaccreditation have been designed to ensure that accredited health departments continue to evolve, improve, and advance, thereby becoming increasingly effective at improving the health of the populations they serve.

Since exploratory work on accreditation began in 2004, CDC has served as a funder and partner in developing, establishing, and continuously improving the national accreditation program. CDC supports accreditation to enhance accountability and quality across the public health enterprise. Given CDC's mission and its commitment to excellence in public health, the agency plays an ongoing role in identifying connections and highlighting where accreditation standards bolster or reinforce programmatic efforts.[6]

Public Health Emergency Preparedness and Response Capabilities

In 2011, CDC established the *Public Health Preparedness Capabilities: National Standards for State and Local Planning*, a set of 15 distinct, yet interrelated, capability standards designed to advance public health emergency preparedness and response capacity. These initial standards pioneered a national capability-based framework that assisted jurisdictional public health departments in accelerating their emergency preparedness and response planning, prioritizing preparedness investments, and further formalizing jurisdictional Emergency Support Function #8 (ESF 8) roles in partnership with emergency management agencies.

To support an "everyday use" model, the capability standards are designed to improve day-to-day effectiveness for a stronger foundation from which to surge when an emergency occurs. Public health agencies are encouraged to strategically incorporate, when applicable, routine public health activities into demonstration projects that test and evaluate jurisdictional capability to respond to public health threats and emergencies.

In 2017, CDC embarked on an initiative to update, clarify, and streamline the capability standards. The initiative included establishing individual work groups for each of the 15 capabilities and four crosscutting work groups to address at-risk populations, tribal populations, environmental health, and pandemic influenza. CDC released the updated version of *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health* in 2018. The updated capabilities better recognize the maturity and experience jurisdictional public health emergency preparedness and response programs have gained since 2011.[7]

History of Alignment between the Initiatives

An extensive history of collaboration exists between CDC staff supporting both public health emergency preparedness and response and public health department accreditation. This longstanding relationship exemplifies the continuing effort to strengthen connections, maintain congruency and alignment, and reduce or eliminate conflicting expectations. Following is a timeline of collaboration and coordination between the public health preparedness capabilities and PHAB accreditation efforts.

- 2011: CDC releases the public health preparedness capabilities, including citations throughout to the PHAB standards (then under development and testing).
- 2011: The PHAB program launches with input from CDC preparedness subject matter experts to finalize the preparedness-related PHAB standards and measures and selected terms in the PHAB glossary.
- 2011–2012: CDC develops an in-depth crosswalk between public health preparedness capabilities and PHAB *Standards and Measures* Version 1.0.
- 2012: A PHAB-preparedness "think tank" is held to explore connections and discuss new synergies.
- 2014: CDC authors a peer-reviewed publication highlighting connections between public health preparedness capabilities and PHAB standards.
- 2014: PHAB releases PHAB Version 1.5 *Standards and Measures,* including updates informed by the think tank, crosswalk, and CDC preparedness staff.
- 2018: PHAB releases PHAB reaccreditation requirements, with preparedness content informed by input from CDC preparedness staff.
- 2018: CDC releases updated public health preparedness capabilities, informed by comparative review with the PHAB standards by CDC accreditation staff.
- 2019: CPR and CSTLTS collaborate to develop a new crosswalk, highlighting both direct and indirect connections between preparedness capabilities and accreditation.
- 2020: CDC releases a new crosswalk of the updated preparedness capabilities and latest accreditation standards, the Accreditation and Preparedness Crosswalk.

Utility of the Crosswalk

The Accreditation and Preparedness Crosswalk is a high-level tool designed to assist public health department leadership and program staff in identifying intersections between both sets of standards. The crosswalk highlights many connections in areas such as surveillance and investigation, emergency response planning, communications, and partnership building. This crosswalk also identifies mutually reinforcing opportunities for collaboration between health department accreditation and public health preparedness and response programs. The value of leveraging linkages between these two sets of standards has been noted in recent national recommendations from the National Academies of Science, Engineering, and Medicine (NASEM).[8]

As illustrated through the crosswalk, areas of development for one program may frequently support the other. Aside from helping to identify connections and efficiencies, the crosswalk can aid in leveraging resources and reinforce consistent approaches for preparedness and response programmatic activities.

Specifically, the crosswalk can help to:

- Identify connections to help determine where public health resources can be leveraged for mutually beneficial purposes.
- Ensure consistent approaches for how preparedness and response activities are conducted or coordinated.
- Foster engagement between staff working on preparedness and response efforts and those coordinating the public health department accreditation efforts.
- Identify preparedness-related information that can be used in accreditation documentation.
- Recognize preparedness-related activities that can be described in the narratives required for reaccreditation.

Navigating the Crosswalk

The crosswalk's PDF table displays the PHAB domains and standards in the vertical axis and the preparedness and response capabilities and functions in the horizontal axis. To use the crosswalk, click on a cell containing a "D" or an "I" and it will highlight the direct or the indirect connection between the PHAB standard and the public health preparedness capability. Click on the associated PHAB standard on the left (in red) or the capability function at the top (in blue) to go to the related standard or function. Click on the button

at the bottom of a page to return to the crosswalk. You can also click on the back button in the upper left of the PDF portfolio.

Following are explanations of **direct** and **indirect** linkages between the PHAB standards and the preparedness capability functions.

- **Direct (D)** indicates strong alignment or connection between PHAB 1.5 *Standards and Measures* and CDC's 2018 *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health*. Direct association may be attributable to significant consistency in language or expectations at varying levels, such as in the PHAB documentation guidance or at the function description, task, or resource element

level of the capability standards. For example, there is a direct connection between PHAB Standard 2.2 and public health preparedness Capability 3: Functions 1 and 2, and Capability 13: Functions 2, 3, and 4.

  - PHAB Standard 2.2: "Contain/mitigate health problems and environmental public health hazards," addresses protocols for containment/mitigation of public health problems and environmental public health hazards (2.2.1), a process for determining when the all-hazards emergency operations plan will be implemented (2.2.2), and after-action reports. This standard is directly connected to numerous preparedness capabilities and functions, including:
    - Capability 3: Functions 1 and 2, which address conducting preliminary assessments to determine the need for activation of public health emergency operations and activating emergency operations, and
    - Capability 13: Functions 2, 3, and 4, which address conducting public health and epidemiological investigations; recommending, monitoring, and analyzing mitigation actions; and improving public health surveillance and epidemiological investigation systems.

- **Indirect (I)** indicates some degree of consistency, alignment, or conceptual affiliation between PHAB 1.5 *Standards and Measures* and CDC's 2018 *Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health*. Indirect association may be less exact or represent an implied connection (wording that does not directly relate but represents the same intent). Indirect connections may represent a potential for stronger alignment if a preparedness-focused activity can be related to a more broadly focused PHAB standard. For example, PHAB Standard 2.2 is indirectly connected with public health preparedness and response Capability 7 and Capability 9.

  - PHAB standard 2.2: "Contain/mitigate health problems and environmental public health hazards," addresses protocols for containment/mitigation of public health problems and environmental public health hazards (2.2.1), a process for determining when the all-hazards emergency operations plan will be implemented (2.2.2), and after-action reports. This standard was found to be indirectly connected to functions in several capabilities, including
    - Capability 7: Mass Care
    - Capability 9: Medical Materiel Management and Distribution

  The connection is indirect because the PHAB standard and measures do not include specific documentation requirements related to mass care or materiel management, but existing jurisdictional protocols may include content to be used during applicable incidents that require mass care and the management of medical materiel.

Notes about Specific Standards

PHAB	Preparedness Capability	PHAB Standard Description	Connection
1.1	None	State/Community Health Assessment	No Connection

The state/community health assessment differs from preparedness assessments such as a jurisdictional risk assessment. However, data from state/community health assessments can be leveraged to inform other preparedness and response activities.

PHAB	Preparedness Capability	PHAB Standard Description	Connection
5.4	1, 3, 4	Maintain an All-Hazards/Emergency Operations Plan	Direct Connection

Direct connections: Preparedness Capabilities 1, 3, and 4 directly reflect many of the same expectations detailed in documentation requirements of PHAB Standard 5.4.

Indirect connections: All other preparedness capabilities were identified as indirect connections because PHAB Standard 5.4 does not emphasize scenario-specific planning or mitigation of specific consequences as described within many of the preparedness capabilities (for example, fatality management, mass care, and responder safety and health). Indirect connections may also represent an implied connection that is not visibly addressed in the current version of the PHAB standard (such as community recovery).

PHAB	Preparedness Capability	PHAB Standard Description	Connection
8.2	None	Ensure a Competent Workforce	Varies

Direct connections: Connections that were identified for preparedness capabilities and functions that specifically address providing training (such as Capability 1: Function 4, which addresses coordinating training to support community involvement).

Indirect connections: Connections that include a training component in the preparedness capability's resource elements and may provide examples useful in meeting the intent of the PHAB accreditation standards (for example, Capability 8: Function 1, which addresses the needs for personnel trained to dispense/administer medical countermeasures).

No connection: No connection was made if the preparedness capability's function did not specifically mention training.

Citations

[1] Public Health Accreditation Board. (2014). PHAB standards and measures, Version 1.5. Public Health Accreditation Board, Alexandria VA. Retrieved from www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf.

[2] Centers for Disease Control and Prevention. (2018). Public health emergency preparedness and response capabilities. Atlanta, GA: US Department of Health and Human Services. Retrieved from www.cdc.gov/cpr/readiness/capabilities.htm

[3] Centers for Disease Control and Prevention. (2018). The Public Health System and the 10 Essential Public Health Services. Atlanta, GA: US Department of Health and Human Services. Retrieved from www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

[4] Public Health Accreditation Board. (2011). PHAB standards and measures, Version 1.0. Alexandria VA: Public Health Accreditation Board. Retrieved from www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf

[5] Corso L, Thomas C. Driving change and reinforcing expectations by linking accreditation with programmatic and strategic priorities. Supplement, Impact of Public Health Accreditation. J Public Health Manag Pract. 2018;24(suppl 3): S109–S113.

[6] Singleton CM, Corso L, Koester D, Carlson V, Bevc CA, Davis MV. Accreditation and emergency preparedness: linkages and opportunities for leveraging the connections. J Public Health Manag Pract. 2014 Jan-Feb;20(1):119-24.

[7]Martinez, D., Talbert, T., Romero-Steiner, S., Kosmos, C., & Redd, S. (2019). Evolution of the Public Health Preparedness and Response Capability Standards to Support Public Health Emergency Management Practices and Processes. *Health security*, *17*(6), 430–438. https://doi.org/10.1089/hs.2019.0076 .

[8]National Academies of Sciences, Engineering, and Medicine. (2020). Evidence-Based Practice for Public Health Emergency Preparedness and Response. National Academies Press, Washington CDC. Retrieved from www.nap.edu/catalog/25650/evidence-based-practice-for-public-health-emergency-preparedness-and-response

Crosswalk between the Public Health Accreditation Board (PHAB) Standards and Public Health Emergency Preparedness and Response Capabilities

(Please see Introduction for context and navigation instructions)

| PHAB Standards | Public Health Emergency Preparedness and Response Capabilities | | |

PHAB

Advancing public health performance

Public Health Accreditation Board

STANDARDS & Measures

VERSION 1.5

Adopted December 2013

Introduction

This Public Health Accreditation Board (PHAB) **Standards and Measures** document serves as the official standards, measures, required documentation, and guidance blueprint for PHAB national public health department accreditation. These written guidelines are considered authoritative and are in effect for the application period beginning on July 1, 2014 and until a new version is released.

The **Standards and Measures, Version 1.5** document provides guidance specifically for public health departments preparing for accreditation and for site visit teams that review and assess documentation submitted by applicant health departments. It also serves anyone offering consultation or technical assistance to health departments preparing for accreditation. It guides PHAB's Board of Directors and staff as they administer the accreditation program. This document assists health departments and their Accreditation Coordinators as they select documentation for each measure. It directs site visit team members in the review of documentation and in determining whether conformity with a measure is demonstrated.

Credibility in accreditation results from consistent interpretation and application of defined standards and measures. The **Standards and Measures, Version 1.5** document sets forth the domains, standards, measures, and required documentation adopted by the PHAB Board of Directors in December 2013. The document also provides guidance on the meaning and purpose of a measure and the types and forms of documentation that are accepted to demonstrate conformity with each measure.

The **Standards and Measures, Version 1.5** document provides assistance to health departments as they work to select the best evidence to serve as documentation. It includes a "Purpose" statement for each standard and measure, a "Significance" statement for each measure, and narrative guidance specific to each required documentation item. PHAB strongly recommends that the health department pay close attention to this document when selecting their most appropriate documentation to meet a measure.

In general, a reference in this document to "the standards" includes references to the entire document including the domains, the standards, the measures, the required documentation, and the guidance.

Domains, Standards, and Measures

Domains are groups of standards that pertain to a broad group of public health services. There are 12 domains; the first ten domains address the ten Essential Public Health Services. Domain 11 addresses management and administration, and Domain 12 addresses governance.

Standards are the required level of achievement that a health department is expected to meet. Measures provide a way of evaluating if the standard is 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, and local health departments. The majority of the measures are the same for Tribal, state, and local health departments and these are designated with an "A" for "all." Where the measure is specific to Tribal, state, or local health departments, the measure addresses similar topics but has slight differences in wording or guidance and will be designated with a "T" for Tribal health departments, "S" for state health departments, and "L" for local health departments. Some measures are designated T/S, some are T/L, and some are S/L.

The structural framework for the PHAB domains, standards, and measures uses the following taxonomy:

Domain	*(example – Domain 5)*
Standard	*(example – Standard 5.3)*
Measure	*(example – Measure 5.3.2)*
Tribal, State, Local or ALL	*(example – Measure 5.3.2 S for state health departments; Measure 5.3.2 L for local health departments; Measure 5.3.2 T for Tribal health departments; and Measure 5.3.2 A for all health departments.)*

Documentation

Health departments vary in size, organizational structure, scope of authority, resources, population served, governance, and geographic region. PHAB's standards, measures, and guidance for documentation apply to all health departments.

PHAB does not intend to be prescriptive about how the health department meets the standards and measures. The health department is expected to ensure that the standards are met for the population that they serve. The focus of the standards, measures, and required documentation is that the health department ensures that the services and activities are provided to the population, irrespective of "how" those services and activities are provided or through what organizational structure or arrangement. Many health departments have formal agreements, contracts, or partnerships with other organizations or agencies to provide services. Health departments must submit to PHAB formal documentation of the partnership or assignment of responsibility to others (MOU, letter of agreement, contract, legislative action, executive order, ordinance, or rules/regulations). PHAB site visitors will want to see evidence of a formal working relationship in these cases.

Likewise, documentation may have been developed by another entity; however it must currently be utilized by the health department. The purpose of PHAB's review of the documentation is to confirm that materials exist and **are in use in the health department being reviewed**, regardless of who originated the material. Documentation, therefore, may be products of other entities.

Documentation could be developed by:

- health department staff;
- state health departments for use by local health departments;
- community partnerships or collaborations;
- partners (e.g., not-for-profits and academic institutions); or
- contracted service providers.

The accountability for meeting the measures rests with the health department being reviewed for accreditation. Documentation that provides evidence of meeting the measure must be provided, even if the documentation is produced by a partner organization and not by the health department. It would be advisable for the health department to include an explanation with its documentation concerning why a measure is met with documentation developed by another organization.

Examples include:

- **Health departments may have formal agreements or partnerships with other organizations to provide particular functions or activities.** For example, a health department might contract with an academic institution to collect primary data. The health department is accountable and responsible for ensuring the high quality, accuracy, and utility of those data, but they do not have to collect the data themselves. They must show that there is a formal mechanism for the partnership or agreement, for example, a Memorandum of Understanding (MOU), a contract, or other written agreement.

Documentation *continued*

- **Health Departments may share functions or services with other governmental agencies.** For example, environmental public health is a function that is sometimes provided by another state or local agency. There are a number of PHAB standards and measures that include or address environmental public health. A health department's documentation should include some examples from environmental public health and may be documents that are produced by that other agency.
- **Health departments, as agencies that are a part of a larger governmental unit, may utilize the policies, procedures, or functions of that governmental unit.** For example, a health department may utilize the human resources system of the government of which it is a part. In this case, the documentation for "human resource policy and procedures manual or individual policies" would be the policies and procedures of the city, county, or state government, for example.

  Likewise, the health department may be part of a "Super Public Health Agency" (an agency that oversees public health, primary care, substance abuse, and mental health), a "Super Health Agency" (an agency that oversees public health, primary care, and Medicaid), or "Umbrella Agency" (an agency that oversees public health, primary care, substance abuse, mental health, Medicaid, and other human service programs). For the example of Measure 11.1.5 A, the health department's human resource policy and procedures manual would be the manual of the Super Public Health Agency, Super Health Agency, or Umbrella Agency, of which it is a part.
- **Tribal, local and state health departments may have agreements with each other about the responsibility for and provision of public health functions.** For example, the state may provide the epidemiology function at the Tribal, state and/or local levels. If the state does not serve this function, the Tribal or local health department would need to provide it some other way. And, the Tribal, state, and local health departments need to coordinate and support one another. Therefore, even when the state, for example, has the primary responsibility to perform a function that is specified in a measure, the Tribal or local health must still provide documentation that it is being performed. The Tribal or local health department cannot dismiss its accountability for meeting the measure, even if the state health department is performing the function.

Some measures require documentation that addresses the entire population that the health department is authorized to serve. For example, the community health assessment and the community health improvement plan are both required to cover the entire health department's population. It is acceptable if these documents cover larger geographic areas, if the parts that address the health department's population can be identified.

Documentation *continued*

SELECTION OF DOCUMENTATION

The health department should select documentation carefully to ensure that it accurately reflects the health department, how it operates, what it provides, and its performance. Site visitors will develop an overall summary of (1) the health department's three greatest strengths, (2) the three most serious/challenging opportunities for improvement, and (3) the department as a functioning health department. They will base this summary on both the review of documentation and findings during the site visit. Therefore, it is critical that the health department select the most relevant and accurate documentation to submit to PHAB.

a. **Relevant to the Domain, Standard, and Measure**
   In order to ensure that the documentation provides evidence of conformity with a measure, the health department must consider the required documentation within the context of the measure, standard, and domain. For example a required piece of documentation may be "documentation of communications, meetings, and/or trainings." It is important to review the measure and standard to know what the documentation of communications, meetings, and/or trainings is meant to demonstrate (e.g., the provision of technical assistance, collaboration on an activity, or sharing of information on a particular topic).

b. **Specific to "Required Documentation" and "Guidance" in the Standards and Measures Version 1.5**
   The documentation submitted to PHAB will be reviewed by site visitors to determine if it is in conformity with the requirements for documentation and to determine the health department's conformity with each measure. Therefore, the documentation that the health department selects for each piece of Required Documentation must be specific to that measure's requirement and the guidance provided.

c. **Focused**
   Documentation should be limited to the most direct and applicable documentation available to meet the documentation requirement. Additional information is not necessary and will not be helpful.

Health departments are encouraged to select documentation from a variety of department programs. Both administrative and program activities are appropriate for documentation to meet various measures. Documentation that is drawn from programs should be selected from a variety of programs to illustrate department-wide activity. Documentation is expected to include programs that address causes of public health issues, determinants of health, and chronic disease and must address the health of the population in the jurisdiction that the health department has authority to serve.

Additionally:

- All documentation must be in use by the health department at the time of the submission of documentation to PHAB.
- No draft documents will be accepted for review by PHAB.
- All documents must show evidence of authenticity (see "Evidence of Authenticity" section).
- All documents must include a date (see "Timeframes" section).

Documentation *continued*

- Documentation submitted to demonstrate conformity with a measure does not have to be presented in a single document; several documents may support conformity with a single measure. An explanation should be included that describes how the documents, together, demonstrate conformity with the measure. The specific section(s) of the documents that addresses the measure must be identified.
- A single document may be relevant for more than one measure and may be submitted multiple times. The specific section(s) of the document that addresses the measure for which it is presented must be identified.
- Documentation must directly address the measure. When selecting documentation, the health department should carefully consider the standard and domain in which the measure is located, as well as the measure itself.
- Documentation should be limited to the most relevant to meet the documentation requirement; more is not better.
- Where documentation contains confidential information, the confidential information must be covered or deleted. A specific example is documents from the human resources department.
- Documents must be able to be submitted to PHAB electronically. Hard copies of documents must be scanned into an electronic format for submission. PHAB will not accept hard copies of any documentation. This applies to documentation that is submitted online to PHAB, as well as any additional documentation requested by the site visitors during the site visit.

Generally, types of documentation that may be used to demonstrate conformity include:

- ***Examples of policies and processes:*** policies, procedures, protocols, standing operating procedures, emergency response/business continuity plans, manuals, flowcharts, organization charts, and logic models.
- ***Examples of documentation for reporting activities, data, decisions:*** health data summaries, survey data summaries, data analyses, audit results, meeting agendas, committee minutes and packets, after-action reports, continuing education tracking reports, work plans, financial reports, and quality improvement reports. When minutes from meetings are used as evidence for documentation requirements, relevant attachments that are referenced in the minutes or were discussed must be included.
- ***Examples of materials to show distribution and other activities:*** email, memoranda, letters, dated distribution lists, phone books, health alerts, faxes, case files, logs, attendance logs, position descriptions, performance evaluations, brochures, flyers, website screen prints, news releases, newsletters, posters, and contracts.

Timeframes

All plans, policies, procedures, processes, contracts, MOUs, and partner agreements must be in use by the health department when they are submitted to PHAB. All programs from which documentation is selected and submitted must be in place when the documentation is submitted.

All documentation used to demonstrate conformity with measures must be dated within the timeframe indicated in the Guidance. The date indicates when the document was created, adopted, reviewed, revised, etc. Site visitors will look for the date on the document. The first purpose of documents being dated is that the dating of all documents is a best practice. Any organization, public health department or otherwise, needs to know when documents were created or last updated both in order to ensure that the information is current and for version control. This is especially true in the public health field as both best practices and populations can change quickly. The second purpose for dates on documents is to enable the PHAB Site Visit Team to assess conformity with PHAB Standards and Measures.

The specificity of the date on the document will depend on the documentation requirement and the type of document. For example, emails provide the full date and time. Policies may include the month, day, and year. Reports may include the month and year. A brochure may include only the year. In most cases the month and year will be required for reviewers to evaluate conformity with the timeframes, though in some cases (for example, brochures) only a year will be required.

Timeframes are determined by starting from the date of submission of the documentation to PHAB. For example, if the timeframe for a plan is five years, the plan must be dated within the five years previous to submission of the documentation to PHAB.

Evidence of Authenticity

All documents must show evidence of authenticity. That is, the document must have a logo, signature, email address, or some other evidence that the document is "authentic" to the applicant health department. The purpose for this requirement is to provide PHAB site visitors with evidence that the documentation does in fact "belong" to the health department being reviewed. It is also a good business practice. In some cases, documentation will be a written policy and will include the signature of a governor, mayor, or health department director. In other cases, documentation may be an email; the "To" and "From" and the email addresses will serve as evidence that the document is "official" health department business. In other cases, a department logo will provide the evidence that the document is an official health department document. For example, a brochure will not have the health department or program director's signature, but it will include the department's logo. Meeting minutes are usually signed but may include the department's logo instead, noting that it is an "official" document. Further, a document developed by a partnership or coalition of which the health department is a member, may or may not include the health department's logo. In this case, evidence of the health department's membership or participation in the partnership or coalition will suffice. Documentation developed by another entity (partner, governmental agency, contractor, etc.) must include evidence that the documentation has been adopted by and is in use by the applicant health department.

Quality Improvement

A goal of public health department accreditation is to promote high performance and continuous quality improvement. PHAB has adopted the following definition of quality Improvement: Quality improvement in public health is the use of a deliberate and defined improvement process that is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in Public Health. ***Journal of Public Health Management and Practice.*** January/February 2010).

Domain 9 focuses on the evaluation of all programs and interventions, including key public health processes, and on the implementation of a formal quality improvement process that fosters a culture of quality improvement. Additionally, PHAB has incorporated the concept of quality improvement throughout the standards and measures and throughout the accreditation process. For example, there are several measures that encourage a broad continuous improvement process of evaluation and improvement: (1) plan or develop programs, process, or interventions, (2) implement, and (3) evaluate for improvement. The accreditation process promotes quality improvement through the provision of a Site Visit Report developed by PHAB trained peer Site Visitors that includes opportunities for improvement. Additionally, accredited health departments are required to submit an annual report to PHAB that describes their progress and quality improvement.

PHAB Acronyms and Glossary of Terms

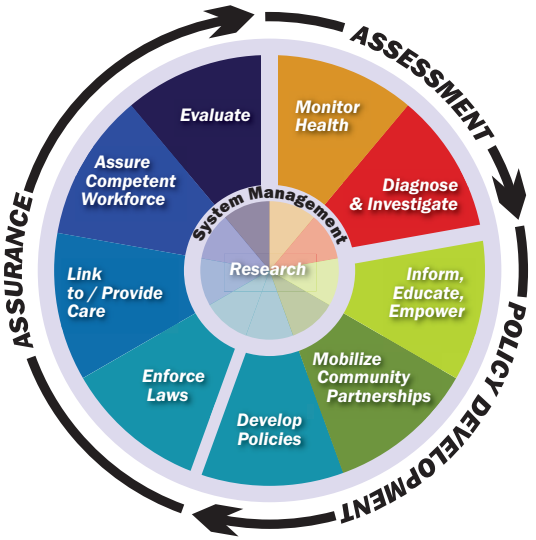
The **PHAB Standards and Measures, Version 1.5** document is accompanied by a sourced **PHAB Acronyms and Glossary of Terms** for many of the terms used in the Standards and Measures. The Glossary also contains a list of acronyms used in the standards. This companion document offers assistance in understanding the standards and measures.

Applicability of Public Health Accreditation Standards

The Public Health Accreditation Board (PHAB) is charged with administering the national public health department accreditation program. To that end, PHAB's scope of accreditation extends only to governmental public health departments operated by Tribes, states, local jurisdictions, and territories.

PHAB's public health department accreditation standards address the array of public health functions set forth in the ten Essential Public Health Services. Public health department accreditation standards address a range of core public health programs and activities including, for example, environmental public health, health education, health promotion, community health, chronic disease prevention and control, infectious disease, injury prevention, maternal and child health, public health emergency preparedness, access to clinical services, public health laboratory services, vital records and health statistics, management /administration, and governance. Thus, public health department accreditation gives reasonable assurance of the range of public health services that a health department should provide. The standards refer to this broad range of work as health department processes, programs, and interventions.

While some public health departments provide mental health, substance abuse, primary care, human services, and social services (including domestic violence), these activities are not considered core public health services under the ten Essential Public Health Services framework used for accreditation purposes. PHAB's scope of accreditation authority does not extend to these areas. Documentation from these program areas generally will not be accepted for public health department accreditation. Similarly, documentation from health care facilities and professional licensing programs and the administration of health care financing systems (e.g., Medicaid) cannot



The Essential Public Health Services and Core Functions
Source: Core Public Health Functions Steering Committee, Fall 1994

Applicability of Public Health Accreditation Standards *continued*

be used for public health department accreditation purposes. (See the PHAB guidance one-page tip sheet on **Accepted Program Areas for PHAB Documentation** at www.phaboard.org).

Some program funding provides support for both population public health and also personal health care services. Documentation related to the program's population public health activities is appropriate for PHAB documentation, while documentation related to the individual, personal, or clinical services provided by the same program, is not appropriate for PHAB documentation. That is, irrespective of the program (for example, WIC, Ryan White, dental health, healthy mothers/healthy babies), documentation of activities related to the provision of individual patient care or clinical services is not appropriate for PHAB documentation. For example, PHAB will accept documentation from a public health education program that informs the public of the need for dental hygiene; PHAB will not accept documentation from a dental clinic that provides individual dental services. Documentation of population health education about the use of condoms for disease prevention is acceptable; documentation on individual HIV testing and counseling is not. Documentation concerning population education about the importance of prenatal care is appropriate, but documentation of the actual prenatal care or well-baby clinics is not. Of course, this holds true for all PHAB Standards and Measures, Version 1.5. For example, documentation concerning client satisfaction surveys or clinic wait times would not be an appropriate example of a QI project for PHAB documentation.

Some public health activities are population based or clinical, depending on how they are provided. For example, a clinic where personal health services are provided will provide vaccinations. This is considered a clinical service. The health department may provide vaccinations as a population based service, e.g., influenza vaccinations available to the public, measles vaccinations for an Amish population where a measles outbreak has occurred, or pertussis vaccinations available to the public due to a rise in incidence of pertussis. These are examples of population based public health services and may be used for PHAB accreditation documentation.

PHAB standards and measures are applicable to public health activities provided by another governmental department, organization, or partner through a formal written agreement. Formal arrangements may be contracts, compacts, or memoranda of agreement. When public health functions are provided by another entity, more than one entity, or through a partnership, the health department must demonstrate how the process, program, or intervention is delivered and how the health department coordinates with the other providers. The fact that an activity is provided by another entity does not abrogate the health department from the responsibility to ensure that it is provided to the population that the health department serves.

Sovereignty and Tribal Public Health Systems

There are 565 federally recognized Tribes (U.S. Federal Register) in the United States, each with a distinct language, culture, and governance structure. Native American Tribes exercise inherent sovereign powers over their members and territory. Each federally recognized Tribe maintains a unique government-to-government relationship with the U.S. Government, as established historically and legally by the U.S. Constitution, Supreme Court decisions, treaties, and legislation. No other group of Americans has a defined government-to-government relationship with the U.S. Government. See U.S. Constitution Article I, Section 8.

Treaties signed by Tribes and the federal government established a trust responsibility in which Tribes ceded vast amounts of land and natural resources to the federal government in exchange for education, healthcare, and other services to enrolled members of federally recognized Tribes. The Indian Health Service (IHS), among other federal agencies, is charged with performing the function of the trust responsibility to American Indians and Alaska Natives. (See Section 3 of the Indian Health Care Improvement Act, as amended, 25 U.S.C. § 1602.) Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975 (ISDEAA), provides the authority for Tribes (includes Alaska Native villages, or regional or village corporations, as defined in or established pursuant to the Alaska Native Claims Settlement Act) to enter into contracts or compacts, individually or through Tribal organizations, with the Secretary of Health and Human Services to administer the health programs that were previously managed by the Indian Health Service. More than half of the Tribes exercise this authority under the ISDEAA and have established Tribal Health Departments to administer these programs, which are often supplemented by other public health programs and services through Tribal funding and other sources.

Format for the Standards and Measures

In this document, the PHAB Standards and Measures are preceded by the domain number and brief description of the domain. The chart below provides an example of the layout for standards, measures, and required documentation, guidance, number of examples, and timeframe for required documentation.

STANDARD:	This is the standard to which the measure applies.

MEASURE	PURPOSE	SIGNIFICANCE
This section states the measure on which the health department is being evaluated.	The purpose of this measure is to assess the health department's . . . This section describes the public health capacity or activity on which the health department is being assessed.	This section describes the necessity for the capacity or activity that is being assessed.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
Documentation of: This section lists the documentation that the health department must provide as evidence that it is in conformity with the measure. The documentation will be numbered: 1. Xxx 2. Xxx a) xxx b) xxx	**1. The health department must provide/document that . . . .** This section provides guidance specific to the required documentation. Types of materials may be described, e.g., meeting minutes, partnership member list, etc. Examples may also be provided here. This section will state if the documentation is department-wide or if a selection of programs' documentation is required.	**X examples** This section states the number of examples required	**X years** This section states the time frame for the date on the documentation. The date on the documentation must be within the number of months or years specified before the date of submission of all of the documentation to PHAB.

Domain 1: Conduct and Disseminate Assessments Focused on Population Health Status And Public Health Issues Facing the Community

Domain 1 focuses on the ongoing assessment of the health of the population in the jurisdiction served by the health department. The domain includes: systematic monitoring of health status; collection, analysis, and dissemination of data; use of data to inform public health policies, processes, and interventions; and participation in a collaborative process for the development of a shared, comprehensive health assessment of the community, its health challenges, and its resources.

DOMAIN 1 INCLUDES FOUR STANDARDS:

Standard 1.1:	Participate in or Lead a Collaborative Process Resulting in a Comprehensive Community Health Assessment
Standard 1.2:	Collect and Maintain Reliable, Comparable, and Valid Data that Provide Information on Conditions of Public Health Importance and On the Health Status of the Population
Standard 1.3:	Analyze Public Health Data to Identify Trends in Health Problems, Environmental Public Health Hazards, and Social and Economic Factors that Affect the Public's Health
Standard 1.4:	Provide and Use the Results of Health Data Analysis to Develop Recommendations Regarding Public Health Policy, Processes, Programs, or Interventions

STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

The purpose of the community health assessment is to learn about the community: the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community resources available to improve the health status. Community health assessments describe the health of the population, identify areas for health improvement, identify contributing factors that impact health outcomes, and identify community assets and resources that can be mobilized to improve population health. Community health assessments are developed at the Tribal, state, and local levels and cover the jurisdiction served by the health department.

A community health assessment is a collaborative process of collecting and analyzing data and information for use in educating and mobilizing communities, developing priorities, garnering resources or using resources in different ways, adopting or revising policies, and planning actions to improve the population's health. The development of a community health assessment involves the systematic collection and analysis of data and information to provide a sound basis for decision-making and action. Community health assessments are conducted in partnership with other organizations and members of the community and include data and information on demographics; socioeconomic characteristics; quality of life; community resources; behavioral factors; the environment (including the built environment); morbidity and mortality; and other social, Tribal, community, or state determinants of health status. The Tribal, state, or local community health assessment will be the basis for development of the Tribal, state, or local community health improvement plan.

STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.1.1 S A state partnership that develops a comprehensive state community health assessment of the population of the state	The purpose of this measure is to assess the state health department's collaborative process for sharing and analyzing data and information concerning state health, state health challenges, and state resources to develop a state level community health assessment.	The development of a state community health assessment requires partnerships with other organizations in order to access data, provide various perspectives in the analysis of data and determination of contributing factors that impact health outcomes, present data and findings, and share a commitment for using the assessment. Assets and resources in the state must be addressed in the assessment, as well as health challenges. Data are not limited to traditional public health data but may include information, for example, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), and social determinants of health. Data are provided from a variety of sources and through various methods of data collection.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Participation of representatives from a variety of state sectors	**1. The state health department must document that the process for the development of a state level community health assessment includes participation of partners outside of the health department that represent state populations and state health challenges.** The collaboration must include various sectors of the state, as appropriate for the state: for example, state government (for example, community development, education, aging, etc.), for-profits (for example, businesses, industries, and major employers in the state), statewide not-for -profits (for example, hospital association, Kids Count, Childhood and Women's Death Review organizations, Cancer Society, public health institutes, environmental public health groups, groups that represent minority health, etc.), voluntary organizations, health care representatives (for example, hospital associations or primary care associations), academia, military installations in the state, and representatives of local or regional health departments in the state and of Tribal health departments in the state.	**1**	**5 years** Documentation must include the month and year.

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
	Representation of two or more populations that are at higher health risk or have poorer health outcomes must be included. Documentation could be, for example, a membership list and meeting attendance records.		
2. Regular meetings or communications with partners	**2. The health department must document that the partnership meets and communicates on a regular basis to consider new data sources, review newly collected data, consider assets and resources that are changing, and conduct additional data analysis.** The frequency of meetings or communications is determined by the partnership and may change, as required by the stage of the process. Meetings and communications may be in-person, via conference calls, or via other communication methods, for example, list-serves or other digital communication methods. Documentation could be, for example, meeting agenda, meeting minutes, and copies of emails. Documentation could also be reports or other documents that show meeting frequency.	**2 examples** of meetings and communications or documentation that identifies the frequency of meetings	**5 years** Documentation must include the month and year.

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
3. The process used to identify health issues and assets	**3. The state health department must document the collaborative process used to identify and collect data and information, identify health issues, and identify existing state assets and resources to address health issues.** The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP) (developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4), and the University of Kansas Community Toolbox (http://ctb.ku.edu/en/node/9). Examples of tools or resources that can be adapted or used throughout, or as part of, the community health assessment process include NACCHO's Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, Tribal Accreditation Readiness Guidebook and Roadmap, Inter Tribal Council of Arizona's Tribal CHA Toolkit, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.	**1 process**	**5 years**

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STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.1.1 T/L Tribal/local partnership that develops a comprehensive community health assessment of the population served by the health department	The purpose of this measure is to assess the health department's collaborative process for sharing and analyzing data and information concerning population health, health challenges, and community resources to develop a community health assessment of the population of the jurisdiction served by the health department.	The development of a Tribal/local level community health assessment requires partnerships with other members of the Tribe/community to access data, provide various perspectives in the analysis of data and determination of factors that impact health outcomes, present data and findings, and share a commitment for using the assessment. Assets and resources in the Tribal/local community must be addressed in the assessment, as well as health challenges. Data are not limited to traditional public health data but include, for example, quality of life, attitudes about health behavior, socioeconomic factors, environmental factors (including the built environment), and social determinants of health. Data are provided from a variety of sources and through various methods of data collection.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Participation of representatives from a variety of sectors of the Tribal or local community	**1. The health department must document that the process for the development of a community health assessment includes participation of partners outside of the health department that represent Tribal/community populations and health challenges.** The collaboration must include various sectors of the community, as appropriate for the community: for example, local government (for example, elected officials, law enforcement, correctional agencies, housing and community development, economic development, parks and recreation, planning and zoning, schools boards, etc.), for-profits (for example, businesses, industries, and major employers in the community), not-for-profits (for example, chamber of commerce, civic groups, hospitals and other health care providers, local Childhood and Women's Death Review organizations, public health institutes, environmental public health groups, groups that represent minority health, etc.), community foundations and philanthropists, voluntary organizations, health care providers (including hospitals), academia, the state health department and Tribal health departments located in the health department's jurisdiction, and military installations located in the health department's jurisdiction.	**1**	**5 years** Documentation must include the month and year.

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
	Representation of two or more populations that are at higher health risk or have poorer health outcomes must be included. Documentation could be, for example, a membership list and meeting attendance records.		
2. Regular meetings or communications with partners	**2. The health department must document that the partnership meets and communicates on a regular basis to consider new data sources, review newly collected data, consider assets and resources that are changing, and conduct additional data analysis.** The frequency of meetings and communications is determined by the partnership and may change, depending on the stage of the process. Meetings and communications may be in-person, via conference calls, or via other communication methods, for example, list-serves or other digital communication methods. Documentation could be, for example, meeting agenda, meeting minutes, and copies of emails. Documentation could also be reports or other documents that show meeting frequency.	**2 examples** of meetings and communications or documentation that identifies the frequency of meetings	**5 years**

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
3. The process used to identify health issues and assets	**3. The health department must document the collaborative process used to identify and collect data and information, identify health issues, and identify existing Tribal or local assets and resources to address health issues.** The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4), and the University of Kansas Community Toolbox (http://ctb.ku.edu/en/node/9). Examples of tools or resources that can be adapted or used throughout, or as part of, the community health assessment process include NACCHO's Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, Tribal Accreditation Readiness Guidebook and Roadmap, Inter Tribal Council of Arizona's Tribal CHA Toolkit, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020, RWJ County Health Rankings and Roadmaps: Assess (http://www.countyhealthrankings.org/roadmaps/action-center/assess-needs-resources).	**1 process**	**5 years**

STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.1.2 S A state level community health assessment	The purpose of this measure is to assess the state health department's comprehensive state level community health assessment of the population of the state.	The state level community health assessment provides a foundation for efforts to improve the health of the population. It is a basis for setting priorities, planning, program development, funding applications, policy changes, coordination of resources, and new ways to collaboratively use state assets to improve the health of the population. A community health assessment provides the general public and policy leaders with information on the health of the population and the broad range of factors that impact health on the population level as well as existing assets and resources to address health issues. The health assessment provides the basis for the development of the state health improvement plan.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A state level community health assessment that includes: a. Data and information from various sources contributed to the community health assessment and how the data were obtained	**1. The state health department must document the identification and description of the state's health and areas of health improvement, the factors that contribute to the health challenges, and the existing state resources that can be mobilized to address them. The state's community health assessment must include all of the following:** a. Evidence that comprehensive, broad-based data and information from a variety of sources were used to create the state health assessment. Qualitative data as well as quantitative data must be utilized. Qualitative data may address, for example, the population's perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Data collection methods include, for example, surveys, asset mapping, focus groups, town forums, and state listening sessions.	**1 community health assessment**	**5 years** Documentation must include the month and year.

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
	Quantitative data may, for example, include vital statistics; graduation rates; morbidity and mortality numbers and rates; and rates of behavioral risks, such as tobacco use. The assessment must include both primary and secondary data. Examples of sources of state secondary data include Federal, Tribal, state, and local health department data, hospitals and healthcare providers, schools, academic institutions, other departments of government (for example, departments of education, transportation, community and economic development, etc.), and statewide not-for-profits. Data sources also include, for example, the County Health Rankings, Community Health Needs Assessment Toolkit, CDC Community Health Status Indicators, CDC Disability and Health Data System, US Census American Factfinder, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, and CDC Wonder. Another data resource is ASTHO's Public Health Data Sources and Assessment Tools: A Resource Compendium to Measure Access and Health Disparities. Examples of primary data include surveys (for example, surveys of high school students and/or parents), focus groups (for example, to discuss community health issues), or other data that the health department collects to better understand contributing factors or elements of secondary data sets.		
b. Demographics of the population	b. A description of the demographics of the population served by the state health department, for example, gender, race, age, socioeconomic factors, income, disabilities, mobility (travel time to work or to health care), educational attainment, home ownership, employment status, immigration status, sexual orientation, etc.		

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
c. Description of health issues and descriptions of specific population groups with particular health issues and health disparities or inequities	c. A description of the health issues in the state and their distribution, based on analyses of the data listed in a) above. The description must include the existence and extent of health inequities between and among specific populations or areas of the state: populations with an inequitable share of poorer health outcomes must be identified.		
d. Description of factors that contribute to the state populations' health challenges	d. A discussion of the contributing causes of the health challenges, for example behavioral risk factors, environmental factors (including the built environment), socioeconomic factors, policies (e.g., taxation, education, transportation, insurance status, etc.), injury, maternal and child health issues, infectious and chronic disease, or the unique characteristics of the state that impact of health status. Multiple determinants of health, particularly social determinants, must be included. Health disparities and high health-risk populations must be addressed. Factors that contribute to higher health risks and poorer health outcomes in specific populations must be considered.		
e. Description of existing state assets or resources to address health issues	e. A listing or description of state assets and resources that can be mobilized and employed to address health issues. These must include other sectors. For example, a state parks system can encourage physical activity. Similarly, a department of agriculture can promote healthful eating, and a state educational policy can encourage the provision of health education.		
2. Opportunity for the state population at large to review drafts and contribute to the community health assessment	**2. The health department must document that the preliminary findings of the state level community health assessment were distributed to the population at large and that their input was sought.** Examples of methods to seek input include: publication of a summary of the findings in the press with feedback or comment forms, publication on the health department's website and website comment form, town forums, listening sessions, newsletters, presentations and discussions at state-wide organizations' meetings (for example the state public health association), etc.	**2 examples**	**5 years**

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
3. The ongoing monitoring, refreshing, and adding of data and data analysis	**3. The health department must document the gathering of information, collection of data, conduct of community dialogues, and/or identification of assets specific to populations and/or geographic areas in the state where health inequities and poorer health indicators were identified in the community health assessment.** Additionally, data analysis is expected to seek to understand health inequities and the factors that create them. Geographic information analysis of socioeconomic conditions would be appropriate information to include in an annual update or supplement. A complete revision or overhaul of the community health assessment is not required, but for a continuous effort to better understand the health of the population through the collection of information and data. Examples of community dialogue include organizing a series of town meetings, conducting focus groups, participating in other state organizations' community meetings (e.g., state injury prevention association meetings, state public health association meetings. etc.), conducting open forums, and conducting group discussions with specific populations (e.g., teenagers, young mothers, residents of a specific area, etc.). Documentation could be, for example, reports of data and their analysis, findings from a focus group, meeting minutes where health issues or needs were discussed, reports of open forums, etc. Documentation of attendance at a meeting is not sufficient; documentation of the information gathered and analyzed is required.	**2 examples** If the CHA is two years or more old, then the examples must be from two different years.	**14 months –** or, if the CHA is 2 years old or older, 1 example within the last 14 months and 1 example from another year since the CHA was adopted.

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STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.1.2 T/L A Tribal/local community health assessment	The purpose of this measure is to assess the Tribal or local health department's comprehensive community health assessment of the population of the jurisdiction served by the health department.	The Tribal or local community health assessment provides a foundation for efforts to improve the health of the population. It is a basis for setting priorities, planning, program development, funding applications, policy changes, coordination of community resources, and new ways to collaboratively use community assets to improve the health of the population. A community health assessment provides the general public and policy leaders with information on the health of the population and the broad range of factors that impact health on the population level as well as existing assets and resources to address health issues. The health assessment provides the basis for development of the Tribal/ local community health improvement plan.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A Tribal or local community health assessment that includes: a. Data and information from various sources contributed to the community health assessment and how the data were obtained	**1. The health department must document the identification and description of the Tribe's or community's health and areas for health improvement, the factors that contribute to the health challenges, and the existing community resources that can be mobilized to address them.** The health assessment must include all of the following: a. Evidence that comprehensive, broad-based data and information from a variety of sources were used to create health assessment. Qualitative data as well as quantitative data must be utilized. Qualitative data may address, for example, the community's perception of health, factors that contribute to higher health risks and poorer health outcomes, or attitudes about health promotion and health improvement. Data collection methods include, for example, surveys, asset mapping, focus groups, town forums, and community listening sessions.	**1 community health assessment**	**5 years** Documentation must include the month and year.

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
	Quantitative data may, for example, include vital statistics; graduation rates; morbidity and mortality numbers and rates; and rates of behavioral risks, such as tobacco use. The assessment must also include both primary data and secondary data. Examples of sources of secondary data include: federal, Tribal, state, and local data; hospitals and health care providers; local schools; academic institutions; other departments of government (for example, recreation, public safety, etc.); community not-for-profits. Data sources also include, for example, the County Health Rankings, Community Health Needs Assessment Toolkit, CDC Community Health Status Indicators, County Health Rankings, CDC Disability and Health Data System, US Census American Factfinder, Dartmouth Atlas of Health Care, National Health Indicators Warehouse, CDC Wonder, and Tribal Epidemiology Centers. Non-traditional and non-narrative data collection techniques are encouraged. For example, an assessment may include photographs taken by members of the Tribe or community in an organized assessment process to identify environmental (including the built environment) health challenges. Examples of primary data include local surveys (for example, surveys of high school students and/or parents), focus groups (for example, to discuss community health issues), or other data that the health department collects to better understand contributing factors or elements of secondary data sets.		
b. Demographics of the population	b. A description of the demographics of the population of the jurisdiction served by the Tribal/local health department, for example, gender, race, age, socioeconomic factors, income, disabilities, mobility (travel time to work or to health care), educational attainment, home ownership, employment status, immigration status, sexual orientation, etc.		

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
c. Description of health issues and specific descriptions of population groups with particular health issues and inequities.	c. A description of the health issues of the population and their distribution, based on the analysis of data listed in a) above. The description must address the existence and extent of health disparities between and among specific populations in the community or areas in the community: populations with an inequitable share of poorer health outcomes must be identified.		
d. Description of factors that contribute to specific populations' health challenges.	d. A discussion of the contributing causes of the health challenges, for example, behavioral risk factors, environmental factors (including the built environment), socioeconomic factors, policies (e.g., zoning, taxation, education, transportation, insurance status, etc.), injury, maternal and child health issues, infectious and chronic disease, resource distribution (e.g., grocery stores), and the unique characteristics of the community that impact on health status. Multiple determinants of health, especially social determinants, must be included. Health disparities and high health-risk populations must be addressed. Community factors that contribute to higher health risks and poorer health outcomes of specific populations must be considered.		
e. Description of existing Tribal or community or assets or resources to address health issues	e. A listing or description of the assets and resources that can be mobilized and employed to address health issues. These must include other sectors. For example, a local park or recreation center can encourage physical activity. Similarly, local farmers' markets can be vehicles to promote healthful eating, and a school district can partner with the health department to provide health education.		
2. Opportunity for the Tribal or local community at large to review and contribute to the assessment	**2. The health department must document that the preliminary findings of the assessment were distributed to the community at large and that the community's input was sought.** Examples of methods to seek community input include: publication of a summary of the findings in the Tribal/local press with feedback or comment forms, publication on the health department's website and website comment form, community/town forums, listening sessions, newsletters, presentations and discussions at other organizations' local meetings, etc.	**2 examples**	**5 years**

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
3. The ongoing monitoring, refreshing, and adding of data and data analysis	**3. The health department must document the gathering of information, collection of data, conduct of community dialogues, and/or identification of community assets specific to populations and/or geographic areas in the community where health inequities and poorer health indicators were identified in the community health assessment.** Additional data analysis is expected to be neighborhood/community specific in order to understand health inequities and the factors that create them. Geographic information analysis of socioeconomic conditions would be appropriate information to include in an annual update or supplement. A complete revision or overhaul of the community health assessment, is not required, but for a continuous effort to better understand the health of the population through the collection of information and data. Examples of community dialogue include organizing town meetings, conducting focus groups, participating in other local organizations' community meetings (e.g., church community meetings, school public meetings, community association meetings or assemblies, etc.), conducting open forums, and conducting group discussions with specific populations (e.g., teenagers, young mothers, residents of a specific neighborhood, etc.). Documentation could be, for example, reports of data and their analysis, findings from a focus group, meeting minutes where health issues or needs were discussed, reports of open forums, etc. Documentation of attendance at a meeting is not sufficient; documentation of the information gathered and analyzed is required.	**2 examples from different years** If the CHA is two years or more old, then the examples must be from two different years.	**14 months –** or, if the CHA is 2 years old or older, 1 example within the last 14 months and 1 example from another year since the CHA was adopted.

Return to Crosswalk

STANDARD 1.1: Participate in or lead a collaborative process resulting in a comprehensive community health assessment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.1.3 A Accessibility of community health assessment to agencies, organizations, and the general public	The purpose of this measure is to assess the Tribal, state, or local health department's efforts to share the community health assessment with other agencies and organizations and to make the assessment results available to the general public.	The community health assessment is a resource for all members of the public health system and the population at large. It is a basis for collaborations and for priority setting, planning, program development, funding applications, coordination of resources, and new ways to collaboratively use assets to improve the health of the population. Other governmental units and not-for-profits will use the community health assessment in their planning, program development, and development of funding applications.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Information provided to partner organizations concerning the availability of the community health assessment	**1. Health departments must document how it inform partners, stakeholders, other agencies, associations, and organizations of the availability of the community health assessment.** Documentation could be, for example, emails to partners and stakeholders providing information of how to access the assessment; announcements in department newsletters; articles in newspapers; digital media, health department tweet or Facebook; public service announcements, and local news announcement.	**2 examples**	**5 years**
2. The availability of the community health assessment findings to the public	**2. Health departments must document how it communicates the community health assessment findings to the public.** Documentation could be, for example, evidence of distribution of the assessment to libraries or the publication of the community health assessment on the department's website. Summaries of the findings could be, for example, published in newspapers, outlined in the department's newsletter, linked to from the department's Facebook page, or published on the department's website.	**2 examples**	**5 years**

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

Reliable data are key building blocks of public health. Health departments must gather timely and accurate data to identify health needs, understand factors that contribute to higher health risks or poorer health outcomes among populations, develop and evaluate programs and services, and determine resources. Health departments require reliable and valid data that can be compared between populations and across time. To best use the information available, health departments require a functional system for collecting data within their jurisdiction and for managing, analyzing, and using the data. Additionally, it is important that health departments share data with other organizations and access others' data.

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.1 A 24/7 surveillance system or set of program surveillance systems	The purpose of this measure is to assess the health department's process for collecting and managing health data for public health surveillance.	Public health surveillance is the continuous, systematic collection, analysis, and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Such surveillance can: serve as an early warning system for impending public health emergencies; document the impact of an intervention or track progress towards specified goals; and monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies. (World Health Organization)

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Process(es) and/or protocol(s) for the collection, review, and analysis of comprehensive surveillance data on multiple health conditions from multiple sources	**1. The health department must provide written process(es) and/or protocol(s) used to collect surveillance data from multiple sources and to review and analyze those data.** Process(es) and protocol(s) must include how data are collected, (e.g., fax, emails, web reports, electronic data, phone calls to the health department or to another site, for example, emergency management or a 9-1-1 call center). The health department defines from whom reports are received. A Tribal surveillance system may include a diverse set of partners, including, but not limited to, federal entities, Tribal epidemiology centers, local and state health departments, or other system partners. Since many Tribal surveillance systems include multiple partners outside of the Tribe, MOUs, MOAs, or other formal written agreements may be used as documentation to demonstrate processes, protocols, roles and responsibilities, confidentiality protection (2 below) and reporting.	**1 department-wide process or protocol, or a set of processes or protocols**	**5 years**

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REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
2. Processes and/or protocols to assure that confidential data are maintained in a secure and confidential manner	**2. The health department must provide written processes and/or protocols that (1) specify which surveillance data are, and which are not, considered to be confidential and (2) assure that confidential data are maintained and handled in a secure and confidential manner.**	**1 department-wide process or protocols, or a set of processes or protocols**	**5 years**
3. 24/7 contact capacity	**3. The health department must document a 24/7 contact system or protocol to collect data from those who report data to the health department.** This may be, for example, a designated telephone line (voice or fax), email addresses, or ability to submit a report on the health department's website. There may be a designated contact person for the health department or a list of contacts. The list may be a call-down list that is used if the primary call is received off-site or by another organization. Reports may be received by a contractor or by a call center (for example a poison control center), via regional or state agreements, or other arrangement. If there is a contract or other form of agreement to provide such services, the contract or agreement must be submitted as part of the documentation.	**1 department-wide contact system or protocol or a set of contact systems**	**14 months**
4. Testing 24/7 contact systems	**4. The health department must provide reports of testing the 24/7 contact system.** The health department determines how the system is tested and the frequency of such testing (which is expected to also be defined in the processes and/or protocols). The testing process can include receipt of a sample report by the various elements of the system. For example, if the system is set up to receive reports by internet, fax, email and a designated phone line, then all elements must be tested to ensure the ability to receive reports.	**2 examples**	**5 years**

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.2 A Communication with surveillance sites	The purpose of this measure is to assess the health department's regular contact with sites who report surveillance data to the health department.	The department ensures that sites are providing timely, accurate, and comprehensive data by communicating with them about their surveillance responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The identification of providers and public health system partners who are surveillance sites reporting to the surveillance system	**1. The health department must provide a list of the individuals or organizations that provide surveillance data to the health department.** Examples of surveillance sites include, for example, health care providers, schools, laboratories, veterinarians, Tribal epidemiology centers, etc.	**1 list**	**14 months**
2. Trainings/meetings held with surveillance sites regarding reporting requirements including reportable diseases/ conditions, and reporting timeframes	**2. The health department must document trainings or meetings held with surveillance site members regarding relevant reporting requirements, reportable diseases/ conditions, and timeframes.** Trainings may address general requirements or topic issue requirements. Training need not be in-person but may be provided online, via webinars, etc. Documentation must include when the training or meeting was held, who attended the training, and what topics were covered. Documentation could be, for example, sign-in sheets and agendas, reports, or minutes of the meeting.	**2 examples of trainings/ meetings**	**14 months**

3. Surveillance data received concerning two different topics	**3. The health department must provide received surveillance data that address two different topics (for example, reports of flu cases, animals with confirmed rabies, a case of antibiotic resistant infection, or environmental public health monitoring data) itemized by reporting site.**	**2 examples of data received** **2 different topics** **2 different occasions**	**14 months**
4. The distribution of surveillance data	**4. The health department must document the distribution of surveillance data to others.** Documentation could be, for example, copies of emails, documented phone calls, newsletters, presentations, and meetings.	**2 examples**	**14 months**

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.3 A Primary data	The purpose of this measure is to assess the health department's capacity to collect primary data concerning health; health inequities; contributing factors or causes of health challenges; or potential policy, public health and/ or community solutions. This measure addresses data other than surveillance data.	Primary data are required to better understand specific situations, issues, and potential solutions. While secondary data can provide a wealth of information concerning the population's health, it is not possible to understand how the reality of those data impact on the population, what the population's perspectives and priorities are or what community resources or resilience can be mobilized to address situations that cause poor health.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Collection of primary quantitative health data	**1. The health department must provide the results of the collection of quantitative primary data from the population (in addition to its surveillance data).** Primary data are data that did not exist before the health department gathered it. The collection of primary quantitative data need not be complicated or costly. The data collection is intended to enhance the knowledge and understanding of the population the health department serves. Data can be obtained from surveys of target groups (e.g., teenagers, the jobless, residents of a neighborhood with higher risks of poor health outcomes). Vital records are considered primary data for state health departments, if the state health department collects them. Documentation could be reports, presentations made, minutes of briefings given, or other communications of the data results and conclusions.	**2 examples**	**3 years**

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2. Collection of primary qualitative health data	**2. The health department must provide the results of the collection of qualitative primary data from the population.** Data must be collected directly from groups or individuals who are at higher health risk. The collection of primary qualitative data need not be complicated or costly. The data collection is intended to enhance the knowledge and understanding of the population the health department serves. These data may address social conditions that have an impact on the health of the population served, for example, unemployment, poverty, lack of accessible facilities for physical activity, housing, transportation, and lack of access to fresh foods. Examples of data collection methods include open ended survey questions, forums, listening sessions, focus groups, storytelling, group interviews, stakeholder interviews, key informant interviews, etc. Documentation could be, for example, reports, presentations made, minutes of briefings given, or other communications of the data results and conclusions.	**2 examples**	**2 years**
3. The use of data collection instruments	**3. The health department must provide standardized data collection instruments that they have used.** Standardized instruments include those that are recognized as national, state-wide, or local data collection tools. They may also be standardized from the standpoint that the same tool was used with all respondents, for example, a local survey developed and distributed to a representative sample of potential respondents. The tool may collect quantitative or qualitative data. Tribes often use qualitative data collection methods, e.g., focus groups, interviews and other methodologies with elders, traditional healers, or ceremonial/cultural leaders. Documentation of qualitative data collection using indigenous methodologies of this type is acceptable. Cultural adaptations of nationally or state-wide recognized data collection tools and methods can be included as examples of data collection instruments. Tribal specific data collection tools that are nationally recognized may or may not exist, in which case, Tribal surveys adapted for their communities will be accepted.	**2 examples** The health department can provide the tools used for the required documentation listed under the Required Documentation 1 or 2 for this measure, or they can be examples from different data collection activities, showcasing different data collection efforts.	**2 years**

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STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.4 S Data provided to Tribal and local health departments located in the state	The purpose of this measure is to assess the state health department's role in and process for sharing data with Tribal and local health departments located in the state.	Tribal and local health departments should have access to data that pertain to the health status of the population they serve. States should have a process in place to share data that they have collected or to which they have access.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of data to local health departments	**1. The state health department must document the provision of primary and secondary data to local health departments located in the state.** Data can be aggregate for the local health department, or for a region of the state. Data could be, for example, collected at the local level and submitted to the state. Some data may be available only at a regional or state level because some local populations are small, and the small data set could impact the statistical power and/or compromise confidentiality. Data could be from registries, (e.g., cancer registries or immunization registries); vital records reports; environmental public health data; or data in web-based infectious disease reporting systems. Data may address social conditions that affect the health of the population served, for example, unemployment, poverty, or lack of accessible facilities for physical activity, housing, transportation, or lack of access to fresh foods. Data may be distributed in an electronic or hard copy format. Documentation could be, for example, distribution lists, distribution protocols, email confirmation of receipt of reports, screen shots of web pages or portals, etc.	**2 examples**	**14 months**

2. The provision of data to Tribal health departments in the state (if one or more is located in the state)	**2. If one or more Tribal health departments is located in the state, the state health department must document the provision of primary and secondary data to the Tribal health department located in the state.** Data can be aggregate for the Tribal health department, or for a region of the state. Data could be collected at the Tribal level and submitted to the state. Some data may be available only at a regional or state level because some local populations are small, and the small data set could impact the statistical power and/or compromise confidentiality. Data could be, for example, from registries, (e.g., cancer registries or immunization registries); vital records reports; environmental public health data; or data in web-based infectious disease reporting systems. Data may address social conditions that affect the health of the population served, for example, unemployment, poverty, or lack of accessible facilities for physical activity, housing, transportation, or lack of access to fresh foods. Data may be distributed in an electronic or hard copy format. Documentation could be, for example, distribution lists, distribution protocols, email confirmation of receipt of reports, screen shots of web pages or portals, etc.	**2 examples**	**14 months**

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.4 L Data provided to the state health department and Tribal health departments in the jurisdiction the local health department is authorized to serve	The purpose of this measure is to assess the local health department's role and process for sharing data with their state health department and Tribal health departments.	State health departments should have access to local data that pertain to health of the state's population. Likewise, Tribal health departments should have access to local data that pertain to the health of the Tribe's population. Local health departments should have a process in place to share local data to which they have access with the state and Tribes (if applicable).

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of data to the state health department and to a Tribal health department (if one or more is located in the jurisdiction the local health department is authorized to serve)	**1. The local health department must document the provision of primary or secondary data to the state health departments and Tribal health departments.** Local health departments that do not have jurisdictions that overlap with the Tribal health departments do not have to demonstrate that they share local data with Tribes, but must provide documented evidence that there is no jurisdictional overlap. Data could be, for example, data submitted for registries (e.g., cancer registries or immunization registries); vital records data; environmental public health data; or data in web-based infectious disease reporting systems. Data may address social conditions that affect the health of the population served, for example, unemployment, poverty, lack of accessible facilities for physical activity, and lack of access to healthy foods. Data may be distributed electronically or via hard copy format. Documentation could be, for example, distribution lists, distribution protocols, email confirmation of receipt of reports, screen shots of web pages or portal, etc.	**2 examples; if a Tribal health department is located within the health department's jurisdiction, one example must be of data provided to a Tribal health department**	**14 months**

STANDARD 1.2: Collect and maintain reliable, comparable, and valid data that provide information on conditions of public health importance and on the health status of the population.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.2.4 T Data provided to the state health department and to local health departments	The purpose of this measure is to assess Tribal health department's role and process for sharing data with the state health department and nearby local health departments.	State and local health departments should have access to Tribal data that pertain to the health of the state population and nearby communities. Tribal health departments should have a process in place to share relevant Tribal health data to which they have access with the state and local health departments.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of data to the state health department and to a local health department	**1. The Tribal health department must document the provision of primary and secondary data to the state health department and to a local health department.** Data could be, for example, data submitted for registries (e.g., cancer registries or immunization registries); vital records data; environmental public health data; or data in web-based infectious disease reporting systems. The data may address social conditions that have an impact on the health of the population served, for example unemployment, poverty, lack of accessible facilities for physical activity and lack of access to healthy foods. Data may be distributed electronically or via hard copy format. Documentation could be, for example, distribution lists, entries in registries, faxed paper reports, distribution protocols, email confirmation of receipt of reports, screen shots of web page or portal, etc.	**2 examples;** one example of data to the state and one example of data provided to a local health department	**14 months**

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STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

Data analysis involves the examination and interpretation of data with the goal of drawing conclusions that inform planning, decision making, program development, evaluation, and quality improvement. The purpose of data analysis is to identify and understand current, emerging, or potential health problems, the contributing causes of health challenges, or environmental public health hazards. Data can identify trends in behaviors, disease incidence, opinions, socioeconomic status, the environment (natural and built), and other factors that aid in understanding health issues and their causes and in designing and evaluating programs and interventions.

STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.3.1 A Data analyzed and public health conclusions drawn	The purpose of this measure is to assess the health department's capacity to analyze and utilize data to identify trends over time, identify clusters, understand health problems, assess behavioral risk factors, detect environmental public health hazards, and recognize social and economic conditions that affect the public's health.	Valid analysis of data is important for assessing the contributing factors, magnitude, geographic location(s), changing characteristics, and potential interventions of a health problem. Data analysis is critical for problem identification, program design, and evaluation of programs for continuous quality improvement.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Analysis of data and conclusions drawn with the following characteristics:	**1. The health department must document the analysis of data with conclusions drawn from the data.** The provision of data used in the analysis is not required, but evidence of the health department's analysis and conclusions is required. Data to be analyzed can include qualitative and/or quantitative, primary and/or secondary data, or combinations of data. Examples include: epidemiologic data, vital statistics, workplace fatality or disease investigation results, cluster identification or investigation results, outbreak investigation results, environmental and occupational public health hazard data, population health or key health indicator data, community survey/focus group results and conclusions, outbreak after action reports, analysis of hospital data, analysis of not-for-profit organizations' data (for example, poison control center data or child health chart book), health disparities data, environmental data, socioeconomic data, stratified racial and ethnic health disparities data, and community health indicator data. Other examples include results of an investigation of a food borne disease outbreak, environmental hazard trends with arsenic in well water, or trends of reported infectious diseases over the past five years.	**2 examples;** one example must be the analysis of qualitative data and one must be quantitative data	**Analysis conducted within 14 months (data may be older)**

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a. The inclusion of defined timelines b. A description of the analytic process used to analyze the data or a citation of another's analysis c. The inclusion of the comparison of data to other agencies and/or the state or nation, and/or other Tribes, and/or similar data over time to provide trend analysis	The data may point out social conditions that have an impact on the health of particular or specific populations served, for example, unemployment, poor housing, lack of transportation, high crime residential areas, poor education, poverty, or lack of accessible facilities for physical activity. a. Data used in the report must be distinct to a specific time period, for example, fiscal year 12-13, calendar year 2014, years 2012-2014. b. The type of analytic process used must be stated and/or be evidence-based with the citation available. The intent is to have conclusions based on solid analysis, not just collection of data. c. The analysis and conclusions must have the quality of comparability. That is, the data can be compared with (1) other similar socio-geographic areas, sub-state areas, the state, or nation, or (2) similar data for the same population gathered at an earlier time to establish trends. Examples of trend analysis include conclusions based on rates of sexually transmitted diseases over the past five years, childhood immunization rates over the past eight quarters, unemployment rates over the past five years, or crime rate over the past two years, etc.		
2. Review and discussion of data analysis	**2. The health department must document the review of data analysis selected for Measure 1.3.1, Required Documentation 1, above.** The intent is to document the sharing of data and their analysis with others. The discussions may be internal, with governing entities, with community groups, with other health or social service organizations, or provided to elected bodies. Documentation could be, for example, minutes or documentation of meetings to show the presentation, review, and discussion of data analysis.	**2 examples**	**14 months**

3. Analysis of data that demonstrates the use of information and data from multiple databases or data sources	**3. The health department must document the analysis of data that combines data from multiple databases of different data topics, (e.g., the housing department's data and the prevalence of asthma) or data sources to support its conclusion.** The analysis of data from multiple data sources demonstrates an understanding of how multiple factors affect health issues. Other data sources include, for example, education, transportation, and housing.	**1 example**	**5 years**
4. Aggregated primary and secondary data and the sources of each	**4. The health department must document the aggregation of primary and secondary data.** Data must be compiled, analyzed, and conclusions drawn. The sources of the data used must also be provided. Documentation could be reports, memos, GIS maps, or other written documents.	**2 examples**	**14 months**

STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.3.2 S Statewide public health data and their analysis provided to various audiences on a variety of public health issues	The purpose of this measure is to assess the state health department's provision of statewide public health data and analysis to various audiences in the state.	Governmental and other public data about the health of the state's population should be shared with others in the state. Other organizations cannot effect change if they are not aware of the status of the health of the state. Sharing data can lead to partnerships to address public health issues.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The distribution of data analysis and findings that address public health issues to specific audiences	**1. The state health department must document the distribution of analytical public health findings to specific audiences in the state.** Examples must include data on one or more specific public health issue, for example, health behaviors; public health laboratory reports; environmental public health hazards reports; disease clusters or trends; vital records and health statistics; or health indicators (e.g., infant mortality rate). Distribution of the data analysis and findings may be targeted to a variety of audiences, for example, public health and health care providers, employers, labor unions and other public health stakeholders, partners, and the public. A range of methods of distribution could be used including: mailing lists, email lists, presentations, workshops, web postings, meeting minutes, published editorials, and press releases. The data or written report of the analysis itself does not have to be distributed, but the contents and findings must be communicated. Thus, while distribution of a hard copy of a report would meet the requirement of the measure, so would a verbal presentation to an audience of the contents of the report. The analysis does not have to be produced by the state health department. The state health department could use reports produced by CDC, or other federal government agencies, an academic institution, or other organization. However, data analysis developed by others must have a connection to the state and the state's population and contain information of public health significance.	**2 examples** Two examples must be from two different years; one from one year and the other from a different year.	**1 example dated within 14 months; the other dated older than 14 months but within 5 years.**

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STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.3.2 L Public health data provided to various audiences on a variety of public health issues	The purpose of this measure is to assess the local health department's provision of community public health data and analysis to the community it serves.	Governmental and other public data about the health of the community should be shared with the community. Community members cannot effect change if they are not aware of the status of the health of the community. Sharing data can lead to partnerships to address public health issues.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The distribution of data analysis and findings to address community public health issues, to specific audiences	**1. The local health department must document distribution of analytical public health findings to specific audiences in the community.** Examples must include data on one or more specific public health issues, for example, health behaviors; disease clusters or trends; public health laboratory reports; environmental public health hazards reports; or health indicators (e.g. infant mortality rate). Distribution of the reports may be targeted to a variety of audiences, including: public health organizations, health care providers, employers, veterinarians, community service groups, local schools, labor unions, other public health stakeholders, partners, and the public. A range of distribution methods could be used including, for example, mailing lists, email lists, presentations, workshops, web postings, meeting minutes, published editorials, and press releases. The data or written report of the analysis itself does not have to be distributed, but the contents must be communicated. Thus, while distribution of a hard copy of the report meets the requirement of the measure, so could a verbal presentation to an audience of community members of the contents of the report.	**2 examples** Two examples must be from two different years; one from one year and the other from a different year.	**1 example dated within 14 months; the other dated older than 14 months but within 5 years.**

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	The report does not have to be produced by the local health department. The local health department could use reports produced by the state, an academic institution, or other organizations. However, data analysis developed by others must have a connection to the jurisdiction and the populations served by the health department and contain information of public health significance.		

STANDARD 1.3: Analyze public health data to identify trends in health problems, environmental public health hazards, and social and economic factors that affect the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.3.2 T Public health data provided to the Tribal community on a variety of public health issues	The purpose of this measure is to assess the Tribal health department's provision of Tribal public health data and analysis to the Tribe it serves.	Governmental and other public data about the health of the Tribe should be shared with the Tribal community. Tribal members cannot effect change if they are not aware of the status of the health of the Tribe. Sharing data can lead to partnerships to address public health issues.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The distribution of data analysis and findings that address community public health issues, to specific audiences	**1. The Tribal health department must document distribution of analytical public health findings to specific audiences in the Tribe.** Examples must include data on one or more specific public health issues, for example, health behaviors; disease clusters or trends; public health laboratory reports; environmental public health hazards reports; or health indicators (e.g., infant mortality rate). Distribution of the data analysis and findings may be targeted to a variety of audiences, including: public health organizations, health care providers, veterinarians, community service groups, local schools, other stakeholders and partners, and the public. A range of distribution methods could be used, including, for example, mailing lists, email lists, presentations, workshops, web postings, meeting minutes, published editorials, and press releases. The data or written report of the analysis itself does not have to be distributed, but the contents and findings must be communicated. Thus, while distribution of a hard copy of the report meets the requirement of the measure, so could a verbal presentation to an audience of community members of the data analysis and findings.	**2 examples** Two examples must be from two different years; one from one year and the other from a different year.	**1 example dated within 14 months; the other dated older than 14 months but within 5 years.**

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	The analysis does not have to be produced by the Tribal health department; the Tribal health department could use reports produced by the state, an academic institution, Tribal epidemiology center, or other organizations. However, data analysis developed by others must have a connection to the Tribal health department and to the populations served by the Tribal health department and contain information of public health significance.		

STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

The development of public health policies, processes, programs, and interventions should be informed by the use of public health data. Data should be shared with others so that they can use it for health improvement efforts.

STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.4.1 A Data used to recommend and inform public health policy, processes, programs, and/or interventions	The purpose of this measure is to assess the health department's use of data to impact policy, processes, programs, and interventions.	Public health policy, processes priorities, program design, and interventions should be based on the most current and relevant data available.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The use of data to inform public health policy, processes, programs, and/or interventions	**1. The health department must document that public health data have been used to impact the development of policies, processes, programs, or interventions or the revision or expansion of an existing policies, processes, programs, or interventions.** The data used to inform the policy, process, program, or intervention must also be included. The data alone will not serve as evidence for this measure. The health department must demonstrate the use of the data. Documentation could be, for example, documented program improvements, or a revised or new policy and procedure. Documentation could also be Tribal Council resolutions and Health Oversight Committee meeting minutes, which demonstrate that data was used to inform policy, processes, programs and/or interventions.	**2 examples** One of the two examples must demonstrate the use of data across multiple data sets, databases, or data source.	**14 months**

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STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.4.2 S Statewide summaries or fact sheets of data to support health improvement planning processes at the state level	The purpose of this measure is to assess the state health department's development and distribution of statewide health data to inform and support others' health improvement efforts at the state level.	In addition to the state health assessment, the state health department should provide health-issue specific or program specific data summaries. These will be summaries of data that focus on a particular issue, for example, health behaviors, health equity factors, or the incidence of infectious diseases. It is important that others have access to health data to inform their program planning and activities at the state level. Health data summaries are used to inform stakeholders and partners about state health issues and to advocate for the health of the state and for the needs identified in the profile.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. State health data summaries or fact sheets	**1. The state health department must provide summaries or fact sheets that condense the state's public health data.** Data summaries may address a combination of public health issues or may focus on a particular health issue regarding the population served. Statewide health data summaries are not the same as a community health assessment. A data summary can take several forms. It can be an overview, summary, or synopsis of a particular health issue, such as cancer or obesity. Or it can address a set of issues, such as health equity or the health issues of the state's adolescents. It may also focus on select key indicators of the health of the state, such as health behaviors like tobacco use or healthful eating. Health data summaries produced by national or federal sources are insufficient documentation of the measure, unless the state health department demonstrates how the data summary was supplemented with additional data collected and analyzed by the state health department.	**2 examples of data summaries**	**5 years**

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	Documentation could be, for example, a summary, fact sheet, brief, overview, a single document of comprehensive data, or a dynamic website with comprehensive state data that is updated as data are available (i.e., web-based dashboard).		
2. Distribution of summaries of state data to public health system partners, community groups and key stakeholders	**2. The state health department must document the distribution of summaries of health data to public health system partners, community groups, Tribal health departments, local health departments, elected officials, or key stakeholders, such as governing entities or community advisory groups.** This may include partners, including community-based organizations, civic groups, and any others who receive services, help in the delivery of services, or support public health services. Documentation could be, for example, a mailing list, email list-serve, posting on the website, press releases, meeting minutes documenting distribution of the profile, presentations, inserts or flyers, or a website of data that is updated as data are available.	**2 examples of distribution of issue specific data summaries or 1 example of provision of comprehensive data**	**5 years**

STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.4.2 T/L Tribal/community summaries or fact sheets of data to support public health improvement planning processes at the Tribal or local level	The purpose of this measure is to assess the Tribal and local health department's development and distribution of health data to inform and support others' health improvement efforts at the Tribal and local level.	In addition to the Tribal/local health assessment, Tribal and local health departments should provide health-issue specific or program specific data summaries. These will be summaries of data that focus on a particular issue, for example, health behaviors, health equity factors, or the incidence of infectious diseases. It is important that others have access to health data to inform their program planning and activities at the local or Tribal community level. Health data summaries are used to inform stakeholders and partners about the health of the community health issue and to advocate for the health of the Tribe or locality and for the needs identified in the profile.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Tribal or community health data summaries or fact sheets	**1. The Tribal or local health department must provide summaries or fact sheets of Tribal/community health data that condense public health data.** Data summaries may address a combination of public health issues or may focus on a particular health issue regarding the population served. Tribal or local health data summaries are not the same as a community health assessment. A data summary can be an in several forms. It can be an overview, summary, or synopsis of a particular health issue, such as cancer or obesity. Or, it can address a set of issues, such as health equity or health issues of adolescents. It may also focus on select key indicators of the health of the community, such as health behaviors like tobacco use or healthful eating. Documentation could be, for example, a summary, fact sheet, brief, overview, a single document of comprehensive data, or a dynamic website with comprehensive data that is updated as data are available (i.e., web-based dashboard).	**2 examples of data summaries**	**5 years**

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	Community health data summaries produced by national, federal including Tribal Epidemiologic Centers), or state health department sources for the local health departments are insufficient documentation of the measure, unless the local health department demonstrates how the data summary was supplemented with additional data collected and analyzed by the local health department.		
2. Distribution of health data summaries to public health system partners, community groups, and key stakeholders	**2. The Tribal or local health department must document the distribution of summaries of health data to public health system partners, community groups, other Tribal and local health departments, elected officials, or key stakeholders, such as governing entities or community advisory groups.** This may include partners, including elected/appointed officials, community based organizations, civic groups and any others who receive services, help in the delivery of service, or support public health services. Documentation could be, for example, a mailing list, email list-serve, posting on the website, press releases, meeting minutes documenting distribution of the profile, presentations, and inserts or flyers, or a dynamic website of data that is updated as data are available.	**2 examples of distribution of issue specific data summaries or 1 example of provision of comprehensive data**	**5 years**

STANDARD 1.4: Provide and use the results of health data analysis to develop recommendations regarding public health policies, processes, programs, or interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 1.4.3 S Support provided to Tribal and local health departments in the state concerning the development and use of summaries of community data	The purpose of this measure is to assess the state health department's support to Tribal and local health departments within the state concerning the development and use of community or Tribal summaries of data.	State health departments have access to and compile data that are not available to Tribal and local health departments. State health departments should share these data with Tribal and local health departments. State health departments also should provide assistance to the Tribal and local health departments on how to use community health data or summaries of data.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Tools and guidance	**1. The state health department must document that data analysis and/or data presentation tools were provided to Tribal and local health departments in the state.** The state may also offer guidance – by phone, electronically, or in person – to help with Tribal and local profile development.	**2 examples**	**5 years**
2. Summaries of community data	**2. The state health department must provide summaries of data of the Tribal and local community.** These must be summaries of data specific to the Tribe or local area and may include data collected by other state agencies, for example, educational attainment, unemployment, types of employment, or crime statistics.	**2 examples**	**5 years**
3. Determination of support or assistance in the analysis and understanding of data appropriate for Tribal and local health departments decision making	**3. The state health department must document that it has asked Tribal and local health departments about what support or technical assistance is needed or requested.** Documentation could be, for example, phone call minutes, faxes, newsletters, memos, meeting minutes.	**2 examples;** 1 example is a Tribal health department if one exists in the state.	**5 years**

4. Technical assistance provided to Tribal and local health departments in the analysis and understanding of data appropriate for public health decision making	**4. The state health department must document the assistance that it provided to Tribal and local health departments concerning the use of summaries of data.** Documentation could be, for example, faxes, newsletters, memos, meeting minutes, phone call minutes.	**2 examples;** 1 example is a Tribal health department if one exists in the state.	**5 years**

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Domain 2: Investigate Health Problems and Environmental Public Health Hazards to Protect the Community

Domain 2 focuses on the investigation of suspected or identified health problems or environmental public health hazards. Included are epidemiologic identification of emerging health problems, monitoring of disease, availability of public health laboratories, containment and mitigation of outbreaks, coordinated response to emergency situations, and communication.

DOMAIN 2 INCLUDES FOUR STANDARDS:

Standard 2.1:	Conduct Timely Investigations of Health Problems and Environmental Public Health Hazards
Standard 2.2:	Contain/Mitigate Health Problems and Environmental Public Health Hazards
Standard 2.3:	Ensure Access to Laboratory and Epidemiologic/Environmental Public Health Expertise and Capacity to Investigate and Contain/Mitigate Public Health Problems and Environmental Public Health Hazards
Standard 2.4:	Maintain a Plan with Policies and Procedures for Urgent and Non-Urgent Communications

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

The ability to conduct timely investigations of suspected or identified health problems is necessary for the detection of the source of the problem, the description of those affected, and the prevention of the further spread of the problem. When public health or environmental public health hazards are investigated, problems can be recognized and rectified, thus preventing further spread of disease or illness.

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.1 A Protocols for investigation process	The purpose of this measure is to assess the health department's ability to conduct standardized investigations with consistent procedures and a set of rules to follow.	Health departments require standard operations, assigned roles and responsibilities, and well thought out coordination to study patterns of health and illness and their associated factors. A standardized approach ensures thorough investigation into the cause of a public health problem or environmental public health hazard and timely response so that further disease and illness can be prevented.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocols that include:	**1. The health department must provide written protocols that include a procedure for conducting investigations of suspected or identified health problems and environmental and occupational public health hazards.** Examples of health problems that require investigation include infectious disease, sexually transmitted disease/infection, injury, chronic disease, chemical emissions, and drinking water contamination, etc.	**1 comprehensive protocol or a set of protocols that covers diseases and environmental health issues**	**24 months**
a. Assignment of responsibilities for investigations of health problems, environmental, and/or occupational public health hazards	a. The protocol must delineate the assignment of responsibilities for investigations of health problems and environmental public health hazards. The assignment may be to a specified position or positions (for example, all environmental public health sanitarians, epi-diagnostic teams, and/or community health outreach staff in the health department) or may be assigned to a named individual. Documentation must include specific responsibilities shown in a procedure, protocol, or flow chart. If this function is carried out in full or in part by a federal agency, other health department, or other entity, then an MOU/MOA or other agreement, must be provided to demonstrate the formal assignment of responsibilities for investigation of health problems and environmental and occupational public health hazards.		

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b. Health problem or hazard specific protocol steps including case investigation steps and timelines, and reporting requirements	b. The protocol must contain protocol steps or procedures for the health problems or hazards that will be investigated, case investigation steps, and timelines related to those problems or hazards, and reporting requirements. The protocols may be in separate documents, may be contained in a manual format, or may be in a single compiled document.		

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.2 S Capacity to conduct and/or support investigations of infectious diseases simultaneously	The purpose of this measure is to assess the state health department's capacity to engage in more than one investigation of infectious disease health problems at the same time.	More than one health problem that requires an investigation may occur simultaneously. Health problems may occur simultaneously in more than one location in the state or may be contained in the jurisdiction of a single or multiple Tribal or local health departments. It is important that the state health department has the capacity to investigate or help support multiple investigations of infectious disease at the same time. The focus of this measure is on investigation of infectious diseases such as influenza, measles, food borne illnesses, or Lyme disease.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Procedures for the conduct of simultaneous investigations	**1. The state health department must provide written procedures that describe how it conducts multiple, simultaneous investigations of infectious diseases.** State health departments often work together with Tribal health departments and local health departments to conduct investigations; the state health department can include contractors and/or relationships with Tribal health departments, local health departments, or other state governmental departments to show the capacity to conduct simultaneous investigations. The state health department does not have to perform all functions of an investigation, but must have the capacity to respond when needed. Documentation could be, for example, response plans, internal plans, staff capacity and expertise, and resources available to the health department from other state governmental departments (for example, the Department of Agriculture or the Department of Environmental Resources).	**1 comprehensive procedure or 2 examples of procedures**	**5 years**

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2. Reviews of investigation reports against procedures	**2. The state health department must provide program audits (internal or external), programmatic evaluations, case reviews, or peer reviews of investigation reports (as compared to written procedures) developed as a result of an investigation of infectious diseases.** The documentation must reference the state health department's capacity to respond to outbreaks of infectious or communicable disease. The documentation could be a completed After Action Report (AAR).	**2 examples of simultaneous investigations**	**5 years**

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STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.2 T/L Capacity to conduct an investigation of an infectious disease	The purpose of this measure is to assess the Tribal/local health department's capacity to implement its protocols for an investigation of infectious disease.	Investigations of infectious disease provide information that allows the health department to understand the best way to control a current outbreak of a disease and to prevent further spread of an outbreak. Sometimes a health problem or hazard requiring investigation occurs where local and state and/or local and Tribal jurisdictions overlap or are adjacent to one another requiring response and coordination between health departments. The focus of this measure is on investigation of infectious diseases, such as influenza, measles, food borne illnesses, or Lyme disease.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Reviews of investigation reports against procedures	**1. The Tribal/local health department must provide audits (internal or external), programmatic evaluations, case reviews, or peer reviews of investigation reports (as compared to written procedures).** The documentation must reference the health department's capacity to respond to outbreaks of infectious disease. The Tribal/local health department can include contractors and/or relationships with the state health department, Tribal health departments in the state, local health departments, or other local government departments to demonstrate the capacity to conduct an investigation. The health department does not have to perform all functions of an investigation of an infectious disease, but must have formal arrangements with others who will participate and support the Tribal/local health department in its investigations. The documentation could be a completed After Action Report (AAR).	**2 examples**	**5 years**

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.3 A Capacity to conduct investigations of non-infectious health problems, environmental, and/or occupational public health hazards	The purpose of this measure is to assess the health department's capacity to implement protocols for an investigation of non-infectious diseases and illnesses and of environmental public health hazards.	Investigations of non-infectious diseases and illnesses and of environmental public health hazards allow the health department to learn how to prevent or mitigate health problems caused by non-infectious health problems and environmental public health hazards.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Completed investigation of a non-infectious health problem or hazard	**1. The health department must provide written reports of a completed investigation of a non-infectious health problem or hazard.** There is no specified format. Non-infectious health problems include: morbidity and mortality associated with emergent and non-emergent health problems that are not infectious, for example, chronic disease, injuries, and environmental public health hazards, as well as their risk factors, including socioeconomic issues. An example of a non-infectious health problem would be an increase in diagnosed diabetes cases or a geographic area with a higher than normal rate of a cancer type. An example of an environmental public health hazard could be arsenic or lead in drinking water, as opposed to an infectious public health hazard, such as a restaurant food-borne outbreak. If this activity is provided through a contract/MOA/MOU, then written assurance that the investigation was completed must be provided. Documentation could be, for example, reports of the investigation, executive summary, presentation or investigation records, including logs and notes.	**2 examples**	**5 years**

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.4 A Collaborative work through established governmental and community partnerships on investigations of reportable diseases, disease outbreaks, and environmental public health issues	The purpose of this measure is to assess the health department's working relationships that are needed to investigate reports of reportable diseases and environmental public health problems.	As a part of conducting investigations, the health department must partner with other governmental agencies and community partners to investigate reports on reportable diseases and environmental public health investigation.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Partnerships with other governmental agencies/ departments and/or key community stakeholders that play a role in investigations or have direct jurisdiction over investigations	**1. The department must provide contracts/MOAs/MOUs/ agreements/funding agreements that document established partnerships for the investigation of outbreaks of disease, health care associated infections, or environmental public health hazards.** These partnerships are with other governmental agencies/ departments and key community stakeholders, and the agreement must state or show that the partner plays a role in investigation. The agreement may state that the partner may have a direct jurisdiction over a specified type of investigation.	**2 examples**	**5 years**
2. Working with partners to conduct investigations	**2. The department must document work with partners to conduct investigations.** Documentation could be investigation reports and records, AARs, meeting minutes, presentations, and news articles	**2 examples** The examples must be from two different investigations of reportable diseases or environmental public health investigations	**5 years**

3. Laboratory testing for notifiable/reportable diseases	**3. The department must provide a list of public health laboratory services presently provided that includes testing for notifiable/ reportable diseases.**	**1 list of public health laboratory services**	**5 years**

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STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.5 A Monitored timely reporting of notifiable/reportable diseases, lab test results, and investigation results	The purpose of this measure is to assess the health department's assurance of timely investigations including reporting of notifiable/reportable diseases, laboratory test results, and reporting investigation results.	A component of assuring timely investigations is the monitoring of reporting notifiable/reportable diseases, laboratory testing, and investigation of results as appropriate and required by law. When all steps are timely, partners can work together to stop the spread of disease.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Tracking log or audit of reports of disease reporting, laboratory tests reports, and/or investigations with actual timelines noted	**1. The health department must provide a tracking log or audit on investigations that includes reporting lab test results and investigation results.** The log is used to track various elements of investigations. Documentation could be a log or a report. The log or report must include timelines.	**1 tracking log or audit of investigations conducted**	**5 years**
2. Applicable laws	**2. The department must provide a copy of laws relating to the reporting of notifiable/reportable diseases.** State health departments must include laws for local health departments to report to the state, as well as for states reporting to CDC. Documentation could be, for example, a screen shot of a posting on a website or a department intranet or a pdf copy.	**1 set of laws**	**The law may be older than 5 years, but the health department should document that the law has been reviewed within 5 years**

STANDARD 2.1: Conduct timely investigations of health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.1.6 S Consultation, technical assistance, and/or information provided to Tribal and local health departments in the state regarding the management of disease outbreaks and environmental public health hazards	The purpose of this measure is to assess the consultation, technical assistance, and information that a state health department provides to Tribal and local health departments in the state concerning the management of disease outbreaks and public health hazards.	The state health department's provision of technical assistance, information, and consultation to Tribal and local health departments on epidemiological, laboratory, and environmental public health assistance improves the effectiveness of the public health response locally and state-wide. The measure includes assistance concerning identifying, analyzing, and responding to infectious disease outbreaks, as well as to environmental and occupational public health hazards.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of consultation, technical assistance, and/or information	**1. The state health department must document how it provides assistance to Tribal or local departments.** This may be at the request of locals or can be initiated by the state. This can include communications that have gone to one or more Tribal or local health departments; meetings at the Tribal, state, or local level; and training sessions and presentations. It can also include email communication – both to individuals and to list-serves. State health department assistance can be for example, onsite, phone consultation, conference calls, webinars, presentations, training sessions, written guidelines, and investigation protocols and manuals.	**2 examples**	**5 years**

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STANDARD 2.2: Contain/mitigate health problems and environmental public health hazards

Health departments must be able to act on information concerning health problems and environmental public health hazards that was obtained through public health investigations. Health departments must have the ability to contain or mitigate health problems and hazards. The containment or mitigation of health problems and environmental public health hazards must be coordinated with other levels of government, other government departments, and other stakeholders.

STANDARD 2.2: Contain/mitigate health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.2.1 A Protocols for containment/ mitigation of public health problems and environmental public health hazards	The purpose of this measure is to assess the health department's ability to contain or mitigate health problems or environmental public health hazards. This includes disease outbreaks. This measure assesses the existence of protocols for the containment or mitigation of public health problems or public health environmental hazards.	Health departments are responsible for acting on information concerning health problems and environmental public health hazards in order to contain or lessen the negative effect on the health of the population. Health departments require standard operations, assigned roles and responsibilities, and well thought out coordination in order to effectively address disease outbreaks. A standardized approach ensures timely response.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocol(s) that address containment/mitigation of public health problems and environmental public health hazards	**1. The health department must provide written protocols or a set of protocols for the containment/mitigation of health problems and hazards.** This includes disease-specific procedures (for example, pertussis, TB) for follow-up and reporting during outbreaks. The protocols must address mitigation, contact management, clinical management, use of prophylaxis and emergency biologics, communication with the public health laboratory, and the process for exercising legal authority for disease control. These protocols may be in a single document or be comprised of many separate documents.	**1 comprehensive protocol or a set of protocols**	**2 years**

STANDARD 2.2: Contain/mitigate health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.2.2 A A process for determining when the All Hazards Emergency Operations Plan (EOP) will be implemented	The purpose of this measure is to assess the health department's ability to know when their All Hazards Emergency Operations Plan (EOP) needs to be put into operation in order to address a natural disaster, terrorist event, disease outbreak or cluster, environmental public health hazard, or other emergency that threatens the population's health.	Protocols for a health department to determine that they need to implement their All Hazards Emergency Operations Plan are necessary to ensure that the plan is put into action when needed and that it is not put into action when it is not needed.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocols that address infectious disease outbreaks describing processes for the review of specific situations and for determining the activation of the All Hazards Emergency Operations Plan	**1. The health department must provide all infectious disease outbreak protocols.** Though these may be the same protocols from 2.2.1 A, the department must highlight the description of the process for determining when the All Hazards Emergency Operations Plan will be implemented.	**1 comprehensive protocol or a set of protocols**	**5 years**
2. Protocols that address environmental public health issues describing processes for the review of specific situations and for determining the initiation of the All Hazards Emergency Operations Plan	**2. The health department must provide protocols that specifically address environmental public health hazards and that describe the process for determining when the All Hazards Emergency Operations Plan will be implemented.**	**1 comprehensive protocol or a set of protocols**	**5 years**

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3. Cluster evaluation protocols that describe the processes for the review of specific situations that involve a closely grouped series of events or cases of disease or other health-related phenomenon with well-defined distribution patterns in relation to time or place or both, and for determining initiation of the All Hazards Emergency Operations Plan	**3. The health department must provide protocols that include cluster evaluation protocols describing the process for determining when the All Hazards Emergency Operations Plan will be implemented.** Cluster evaluations will provide evidence of an unusual number of health events, for example, SARS, influenza, food poisoning, health care associated infections (e.g., MRSA), or unusual symptoms in a group, together in time and location. A cluster evaluation is differentiated from an outbreak in that a single case of some infectious diseases may trigger the use of an outbreak protocol (e.g., small pox or polio).	**1 comprehensive protocol or a set of protocols**	**5 years**

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STANDARD 2.2: Contain/mitigate health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.2.3 A Complete After Action Reports (AAR)	The purpose of this measure is to assess the department's development of descriptions and analysis of performance after an emergency operation or exercise. This measure assesses the existence of After Action Reports.	A process for After Action Reports provides a way for the health department to assess its performance during an emergency operation for quality improvement. It identifies issues that need to be addressed and includes recommendations for corrective actions for future emergencies and disasters. An AAR is to be completed when an infectious disease outbreak occurs, an environmental public health risk has been identified, a natural disaster occurs, and any other event occurs that threatens the public's health. While AARs have been used for drills and exercises as part of All Hazards Plans (see 5.4.3 A), the focus of this measure is concerning the determination of when AAR methodology is applied to actual events that threaten the health of the people living in the jurisdiction of the health department.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocol describing the processes used to determine when events rise to significance for the development and review of an AAR	**1. The health department must provide a written description of how it determines if an event has risen to the level of significance requiring an AAR.** Not every event will require an AAR. For example, a food borne outbreak may have 10 positive cases before being designated as significant enough to require an AAR. The process must address infectious disease outbreaks, environmental public health hazards, natural disasters, and other threats.	**1 protocol**	**5 years**

2. A list of all events that occurred, including outbreaks and environmental public health risks	**2. The health department must provide a list of significant events that have occurred within the last five years.** The list must include all events that met and did not meet the level of significance to require an AAR. The list must include, at minimum, the event name, dates of the event, and type of event (e.g., natural disasters, such as floods or hurricanes; manmade disasters, such as a toxic chemical release or pollution; and terrorism, such as anthrax or explosions). The list must include all outbreaks, environmental public health risks, natural disasters, or other events that threaten the public's health.	**1 list**	**5 years**
3. Completed AAR for two events	**3. The health department must provide completed AARs.** An AAR documents successes, issues, and recommended changes in investigation and response procedures or other process improvements. The AARs must report what worked well, what issues arose, what improvement in protocols are indicated, and recommended improvements.	**2 examples of separate events**	**5 years**

STANDARD 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

Successful investigation and mitigation of public health problems and environmental hazards will often depend on laboratory testing, epidemiologist involvement, and environmental public health expertise. These areas of expertise provide vital support to an investigation and are a part of the capacity that a department should have to respond to health problems and environmental public health hazards.

STANDARD 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.3.1 A Provisions for the health department's 24/7 emergency access to epidemiological and environmental public health resources capable of providing rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards	The purpose of this measure is to assess the department's capacity for rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards.	Health departments need the capacity to respond to public health emergencies. The department needs to have access to epidemiological and environmental public health resources that can support the rapid detection, investigation, and mitigation of problems and hazards. This access must be available to the department 24/7.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Policies and procedures ensuring 24/7 coverage	**1. The health department must provide policies and procedures outlining how the health department maintains 24/7 access to support services in emergencies.** These policies and procedures may be contained in the All Hazards Emergency Operations Plan or may be separate policies and procedures. These resources may be within the department, or the department can have agreements with other agencies, individual contractors, or a combination in order to be responsive 24/7.	**1 comprehensive policies and procedures document or a set of policies and procedures**	**5 years**

2. Process to contact epidemiological and environmental public health resources	**2. The health department must provide the call down list that is used to contact epidemiological and environmental public health resources.**	**1 call down list**	**5 years**
3. Contracts/MOAs/MOUs/ mutual assistance agreements detailing relevant staff	**3. The health department must provide a list and description of contracts, MOA/MOUs, or mutual assistance agreements that define access to resources to assist in 24/7 capacity for emergency response.**	**1 list**	**5 years**

STANDARD 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.3.2 A 24/7 access to laboratory resources capable of providing rapid detection, investigation and containment of health problems and environmental public health hazards	The purpose of this measure is to assess the department's access to needed laboratory services to provide rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards.	Emergency laboratory services are critical to recognize agents for the development of an appropriate public health rapid response. The department must have access to public health laboratory resources that can support the rapid detection, investigation, and containment of problems and hazards. This access should be available to the department 24/7.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Laboratory certification	**1. The health department must provide documentation of laboratory capacity.** Laboratory capacity may be within the health department, may be provided by reference laboratories, or a combination of both internal and external support. The health department must provide documentation that the laboratory has accreditation, certification, and licensure appropriate for all the testing that it performs (i.e., CLIA License, EPA Drinking Water Certification, FDA Certification for Milk Testing, etc.)	**Accreditation documentation, certification, and/or licensure appropriate for all the testing that is performed**	**5 years**

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2. Policies and procedures ensuring 24/7 coverage	**2. The health department must provide policies and procedures that assure 24/7 laboratory coverage.** These resources may be within the department, or the department can have agreements with other agencies, individual contractors, or a combination in order to be responsive 24/7. These policies and procedures may be contained in the All Hazards Emergency Operations Plan or may be separate policies and procedures. Documentation could be contracts, MOAs/MOUs, or mutual assistance agreements that the department has with other public and private laboratories to provide support services.	**1 set of policies and procedures or policies and procedures, MOUs, or agreements**	**5 years**
3. Protocols for the health department's handling and submitting of specimens	**3. The department must provide protocols for the health department's handling and submitting of specimens.**	**1 comprehensive protocol or a set of protocols**	**5 years**

STANDARD 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.3.3 A Access to laboratory and other support personnel and infrastructure capable of providing surge capacity	The purpose of this measure is to assess the department's support personnel and infrastructure capacity for providing surge capacity for rapid detection, investigation, and containment/mitigation of public health problems and environmental public health hazards.	Access to additional support personnel is important in the case of an emergency, such as a bio-terrorism event or disease outbreak, when response needs of the health department exceed normal capacity of health department staff.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Surge capacity protocol that pre-identifies support personnel to provide surge capacity	**1. The health department must provide the protocol, procedure, or policy that identifies support personnel who will be called on to provide surge capacity.** This could refer to support staff within the health department who can assist during times of response and who would be performing duties outside their routine assignments; or it could be a listing of support personnel from outside the health department who would be available to assist the department. The protocol must include access to public health laboratory services.	**1 protocol**	**5 years**
2. Access to surge capacity staffing list	**2. The health department must provide the staffing list(s) for surge capacity that refers to both the staffing needed for a surge response and how department staff will fill those needs.** Included with this documentation must be a description of how staff will access this information. Access could be through various methods, including: web or intranet, central location in the facility, or distributed to those positions that have surge capacity assignments. The HD must also demonstrate that staff on the list have access to the list. Positions on the list may include, for example, nursing, health education specialist, communications, IT, logistics, veterinarian and animal caretaker, environmental health specialist, laboratory, and administrative personnel. This could be a part of an All Hazards/ERP or a separate protocol.	**1 list or lists**	**5 years**

3. Availability of equipment	**3. The health department must provide a document detailing the availability of equipment to support a surge in order to demonstrate the availability of additional infrastructure for a response.** For example, equipment may be used for transportation, field communications, Personal Protective Equipment (PPE), etc.	**1 document**	**5 years**
4. Training/exercise schedule for surge personnel	**4. The health department must provide a schedule for training or exercises to prepare personnel who will serve in a surge capacity (for example, ICS or PPE training).** This does not have to be the sole focus of the training or exercise, but must be a component of the training.	**1 schedule**	**2 years**
5. Contracts/MOAs/MOUs/ mutual assistance agreements for additional staff capacity for surge situations	**5. The health department must provide a list and description of contracts, MOAs/MOUs, and/or mutual assistance agreements providing additional staff and services, including laboratory services, for surge capacity.** Any of the contracts or agreements for this measure can consist of separate documents or a single agreement covering several aspects of support.	**1 list**	**5 years**

STANDARD 2.3: Ensure access to laboratory and epidemiological/environmental public health expertise and capacity to investigate and contain/mitigate public health problems and environmental public health hazards.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.3.4 A Collaboration among Tribal, state, and local health departments to build capacity and share resources to address Tribal, state, and local efforts to provide for rapid detection, investigation, and containment/ mitigation of public health problems and environmental public health hazards	The purpose of this measure is to assess coordination and collaboration between Tribal health departments, state health departments, and local health departments in order to share resources for rapid detection, investigation, and containment/ mitigation of public health problems and environmental public health hazards.	Public health problems and environmental public health hazards are not always contained in the jurisdiction of the health department. Tribal, state, and local health departments have the responsibility to work together to provide rapid detection, investigation and containment/mitigation. In most public health situations requiring investigation and mitigation, the state health department and local health department must be partners in the response. Likewise, Tribal health departments network with local and state entities for mitigation, detection, and containment with contracts, memorandums of understanding or agreement, as approved by the Tribal government. Seamless coordination and communication are necessary for the most effective use of resources.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Shared resources and/or additional capacity	**1. The health department must document Tribal, state, and local health departments working together to build capacity and share resources.** Documentation could be policies and procedures, MOUs, or other written agreement that demonstrate plans to communicate and collaborate in addressing public health problems and environmental public health hazards. Other forms of documentation could include meeting minutes that evidence discussion and decisions to work together, as well as After Action Reports that describe coordination.	**2 examples**	**5 years**

2. Joint exercises for rapid detection, investigation, and containment/ mitigation of public health problems and environmental public health hazards	**2. The health department must document joint exercises that show the Tribal, state, and local levels work together to test or implement shared resources and build capacity during the exercise.** Documentation could be AARs or other records.	**2 examples;** one example must include a Tribe, if one exists in the health department's jurisdiction.	**5 years**

STANDARD 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

Reliable and timely communication with partners and the public is important to ensure informed and appropriate responses to public health problems and environmental public health hazards.

STANDARD 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.4.1 A Written protocols for urgent 24/7 communications	The purpose of this measure is to assess the department's written protocols for communications during detection, investigation, and mitigation of urgent public health problems and environmental public health hazards that may occur at any time.	Urgent public health problems and environmental public health hazards require a community-wide response. Accurate and timely information is necessary to ensure an appropriate and effective community response. Partners and the public need to know how to contact the health department to both report and receive information about a public health emergency or environmental public health risk.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocol for urgent 24/7 communications	**1. The health department must provide a communication protocol that provides a means for the department to contact health care providers, response partners, the media, and others, 24/7.** The protocol must include the contact information (for example, phone numbers, email addresses, and website addresses for relevant partners). The health department must have duplicative means to get in touch with partners.	**1 protocol**	**14 months**
2. Availability of information to partners (and/or the public) on how to contact the health department to report a public health emergency or environmental/ occupational public health risk 24/7	**2. The health department must document the provision of information to partners and the public about how to contact the health department to report a public health emergency, risk, problem, or environmental or occupational public health hazard.** Partners may include: law enforcement, schools, hospitals, veterinarians, and government agencies. Documentation could be a screen shot of a web page with contact information.	**1 example**	**5 years**

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3. The method for partners and the public to contact the health department 24/7	**3. The health department must document how partners and the public contact the health department 24/7.** An after-hour answering service or pager service could provide this capacity. Documentation could be, for example, a script or transcript of an answering service.	**1 example**	**5 years**

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STANDARD 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.4.2 A A system to receive and provide urgent and non-urgent health alerts and to coordinate an appropriate public health response	The purpose of this measure is to assess the health department's ability to receive and issue health alerts and to communicate and coordinate the appropriate public health response with health care providers, emergency responders, and communities on a 24/7 basis.	Speedy and accurate communications with health care providers, emergency responders, and other partners concerning health alerts facilitates their understanding of the scope of the emergency, the steps necessary to respond to it, and the protection of the community and responders. Communication allows the development of effective and coordinated responses to urgent public health problems and environmental public health hazards.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A tracking system for the receipt and issuance of urgent and non-urgent health alerts	**1. The health department must document that it has established or participates in a Health Alert Network (HAN) or similar system that receives and issues alerts 24/7.** A HAN usually has the capacity to issue response measures or information related to the risk, hazard or problem. The tracking system or Health Alert Network may be a state system in which Tribal or local health departments participate. The Tribal or local system may establish a smaller system for providers and responders within the jurisdiction of the health department. Some jurisdictions have established a Joint Information Center (JIC) with a public information officer for the health department; health departments may provide evidence of this as documentation.	**1 tracking system or health alert network**	**5 years**
2. Reports of testing 24/7 contact and phone line(s)	**2. The health department must provide reports of testing the 24/7 contact procedure.** This testing must include normal work hours and after hours. Email contact, phone lines, pager, website and other contact points with the department must be tested where applicable.	**2 examples**	**5 years**

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STANDARD 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.4.3 A Timely communication provided to the general public during public health emergencies	The purpose of this measure is to assess the health department's ability to provide information to the public during a public health emergency.	During a public health emergency, the health department functions as the expert. Speedy and accurate communications with the public during public health emergencies facilitates their understanding of the seriousness of the emergency and informs them of the actions they should and should not take in response to the public health emergency. In the absence of accurate information, false information will be created and spread. Public information also lets the public know that the public health department is working to protect the community. A key mechanism to reach the public is the media.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Communications plan, procedure, or process to provide emergency information to the public	**1. The department must demonstrate how it communicates with and provides information to the public.** Documentation must provide evidence of outreach and communication methods designed specifically to communicate with the disabled, linguistically challenged, and other members of the public that require particular communication considerations. The measure deals with public health emergencies (for example, an outbreak of an infectious disease, a release of toxic chemicals, or the need to boil water during a flood or water main break); documentation must demonstrate processes to ensure timely communication with the public during an emergency. General public health educational materials are not relevant for this measure. The process must include a variety of means to communicate information to the public, including, for example, posting on a website, distribution of printed materials (brochures, flyers, factsheets, inserts), fax broadcast to all providers and other responders, automated call systems, digital media (e.g., Twitter) and email list-serves.	**2 examples**	**5 years**

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2. Communications through the media to provide information during a public health emergency	**2. The department must demonstrate the use of the media to communicate information to the public during a public health emergency.** Documentation must provide evidence of relationships with media, organizations, and outlets for reaching the disabled, the non-English speaking public, and other members of the public that require particular communication considerations. The measure deals with public health emergencies and the documentation must demonstrate timely communication with the media during an emergency. General public health educational information is not relevant for this measure. Documentation could be, for example, a press conference, media packets, press release, public service announcement, or video of a televised interview.	**2 examples**	**5 years**

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STANDARD 2.4: Maintain a plan with policies and procedures for urgent and non-urgent communications.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 2.4.4 S Consultation and technical assistance provided to Tribal and local health departments on the accuracy and clarity of public health information associated with a public health emergency	The purpose of the measure is to assess the state health department's support to Tribal and local health departments' efforts to inform the public concerning an outbreak or an environmental or other public health emergency.	The state health department has a role in serving as a resource to Tribal and local health departments for communication associated with outbreaks and emergencies. An important element in communication is consistent messaging from partners. The state has a role in crafting messages that are shared to ensure that public health information is accurate and clear. The measure specifies the assistance on information that is associated with an outbreak, an environmental event, or other emergency.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Consultation, technical assistance, or guidance provided to Tribal and local health departments	**1. The state health department must document the provision of consultation, technical assistance, or guidance provided to Tribal and local health departments.** The state health department does not have to demonstrate that the Tribal and local health departments use the services from the state, but consultation and technical assistance must be available if requested. Documentation could be, for example, minutes of meetings or conference calls. Meeting or training agenda or presentations can be provided and must include a list of Tribal or local health attendees. Assistance could also be documented by emails or list-serves sent to Tribal and local health departments.	**2 examples;** one example must include a Tribe, if one exists in the health department's jurisdiction.	**5 years**
2. Guidelines for accurate and clear communication to the public	**2. The state health department must provide communication guidelines, protocols, or written assistance for Tribal and local departments.** Guidelines must include information about developing clear and accurate public health information during an outbreak, crisis, or emergency to prepare Tribes and local health departments for such an occurrence.	**1 set of guidelines**	**5 years**

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Domain 3: Inform and Educate about Public Health Issues and Functions

Domain 3 focuses on informing and educating the public. This domain assesses the health department's processes for continuing two-way communication with the public as standard operating procedure.

A role of the health department is to provide accurate and reliable information about how to protect and promote individual and family health. Health departments provide information about healthy behaviors, such as good nutrition, hand washing, and seat belt use. The public needs access to accurate and timely information in the case of particular health risks like H1N1, a food borne disease outbreak, or an anthrax attack. For information to be actionable, it must be communicated in a language and format that the population can access and understand. Messages need to be culturally appropriate and trusted. Public health departments also have a responsibility to educate the public about the mission, value, roles, and responsibilities of the health department and the meaning and importance of public health. Building and maintaining a positive, trustworthy reputation in all of its diverse communities is essential.

These educational responsibilities require a continuing flow of information. To be effective, information cannot be one-way. For the health department to communicate with the public accurately, reliably, and in a timely manner, it must gather and use information that it receives from federal, Tribal, state, and local health departments. To facilitate communication, it needs to have a relationship with community partners and the population and sub-groups of the population that it serves. Communication requires dialogue with the target population to assure that the message is relevant, culturally sensitive, and linguistically appropriate. Communication methods are changing rapidly through digital media such as Twitter and Facebook. Selected communication methods must be appropriate for the target audience, the urgency of the communication, and the type of information. In addition, the science of public health branding is developing rapidly. Branding is important for the department's image, reputation, and perceived value.

DOMAIN 3 INCLUDES TWO STANDARDS:

Standard 3.1:	Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to Support Prevention and Wellness
Standard 3.2:	Provide Information on Public Health Issues and Public Health Functions Through Multiple Methods to a Variety of Audiences

STANDARD 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.

Health promotion involves a wide range of social and environmental changes that allow and encourage the population to be healthy. Health promotion policies, programs, processes, and interventions are the mainstay of public health improvement efforts. Health promotion can involve health education, communication, working with the media and other stakeholders, social marketing, health equity, behavior change, environmental changes, community mobilization, community development, and policy changes.

Health education is an important component of encouraging the adoption of healthy behaviors. Health education provides the information needed to improve and protect their health. Health education involves gathering knowledge about the health issue and the target population and sharing that information in a manner and format that can be used effectively by the population.

STANDARD 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.1.1 A Information provided to the public on protecting their health	The purpose of this measure is to assess the health department's dissemination of accurate information to the populations that it serves concerning health risks, health behaviors, disease prevention, and wellness approaches.	A key activity in promoting population health is providing public health information that encourages the adoption of healthful behaviors and activities. To be effective, information should be appropriate for the target audience. It must be accurate, timely, and provided in a manner that can be understood and used effectively by the target population. Public health information can address a broad range of public health promotion messages: • Health risks, for example, high blood pressure or high cholesterol. • Health risk behaviors, for example, tobacco use or unprotected sexual activity. • Disease, illness, or injury prevention, for example, seat belt use or immunizations. • Wellness, for example, health nutrition or physical activity. Health information could address a combination of these targets and messages. For example, unprotected sex, needle sharing, and HIV transmission could combine aspects of health risks, health behaviors, and prevention. For the information to be trusted and understood, health education messaging must not be contradictory or confusing. Ideally, messaging needs to be coordinated with others who are providing public health information to the public.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of information to the public on health risks, health behaviors, disease prevention, or wellness	**1. The health department must document the provision of information to the public to address health risks, health behaviors, disease prevention, and/or wellness. Information must be accurate, accessible, and actionable.** The need for cultural competence and consideration of health literacy must be taken into account. Information is expected to be provided in plain language with everyday examples.	**2 examples** (See details on following page.)	**5 years**

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	Documentation must note the target group or audience, the program area, the date the information was shared or distributed, and the purpose for the information. Documentation could be, for example, a public presentation, distribution of a press release, media communications, brochures, flyer, or public service announcement.	The two examples can relate to the same message area, such as two items addressing disease prevention issues. The two examples must, however, be from different program areas, one of which must address a chronic disease program, for example, diabetes, obesity, heart disease, HIV, or cancer.	
2. Consultation with the community and target group during the development of the educational material/ messages	**2. The health department must document steps taken to solicit input from the target audience during the development of messages and materials.** Input is intended to help shape the final content, cultural competence, language, and real life situations of the target audience. The role of social and environmental factors must be addressed (rather than focusing primarily on the individual). Documentation could be, for example, a report of findings from a focus group, key informant interviews, or pull-aside testing. Documentation could also be minutes from a town meeting with the target population or a meeting of an advisory group representing the target population.	**2 examples** One example must come from one of the two program areas from which documentation was provided in 1, above	**5 years**
3. Health education messages that are coordinated with Tribal, state, and/ or local health departments; and/ or community partners	**3. The health department must document communication with other health departments (Tribal, state, or local) or community partners to promote unified messaging.** Documentation could be, for example, a fact sheet, an email or memorandum, meeting minutes where messaging was discussed, or documented phone conversation discussing the message.	**2 examples**	**5 years**

STANDARD 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.1.2 A Health promotion strategies to mitigate preventable health conditions	The purpose of this measure is to assess the health department's strategies to promote health and address preventable health conditions.	Health promotion aims to enable individuals and communities to protect and improve their own health. Health promotion encourages positive health behaviors. Health promotion is a combination of health education, community change, environmental change (including the built environment) and organizational and social supports that provide conditions conducive to the good health of individuals, groups, and communities. Health promotion combines educational, political, regulatory, social, and organizational efforts.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A planned approach for developing and implementing health promotion programs	**1. The health department must document a planned approach for developing and implementing health promotion materials and activities.** A planned approach could be documented through, for example, policies and procedures, a health promotion communications plan, the use of a communications model or methodology (for example, CDCynergy), or other documentation that describes how health promotion programs are developed (including the use of data and community input).	**1 example**	**5 years**
2. Development and implementation of health promotion strategies	**2. The health department must document the development and implementation of health promotion strategies.** The documentation must show how the strategies: • Are evidence-based, rooted in sound theory, practice-based evidence, and/or promising practice. • Were developed with engagement of the community, including input, review, and feedback from the target audience.	**2 examples** The examples must come from two different program areas, one of which must address the prevention of a chronic disease.	**5 years**

	• Focus on social and environmental factors (such as air quality or the built environment) that create poor health, discourage good health, or encourage individual behavioral factors that impact negatively on health. • Use various marketing or change methods including, for example, digital media and social marketing, as appropriate. • Were implemented in collaboration with stakeholders, partners, and the community. Examples of health promotion efforts include biking pathways, farmers markets, public meeting places (to encourage social interaction), distribution of child safety devices, walking clubs, and smoke free zones. Documentation could be, for example, a portion of a program plan, a portion of a program strategic plan, minutes of a program planning meeting, part of a report developed for submission to a funding agency, evaluation report of the program, or other official description of the strategy. Due to the limited availability of evidence-based practices or promising practices in Tribal communities, Tribes may provide examples of practice-based evidence used to adapt models or create models based on a cultural framework.		
3. Engagement of the community during the development of a health promotion strategy	**3. The health department must document that it solicited review, input, and/or feedback from the target audience during the development of the health promotion strategy.** Documentation must include a description of the process and the results. Documentation could be, for example, findings from a focus group, key informant interviews or pull-aside testing. It could also include minutes from a town meeting or planning meeting with the target population or a meeting of an advisory group representing the target population.	**2 examples** One of the examples must be from one of the two program areas from which documentation was provided in Required Documentation 2, above.	**5 years**

4. Implementation of strategies in collaboration with stakeholders, partners, and/or the community	**4. The health department must document that implementation of the strategies was in collaboration with stakeholders, partners, and/or the community.** The stakeholders and partners associated with the strategy must be listed or community described. The documentation must define the stakeholders', partners', and/or community's relationship to and role in the strategy. Documentation could be minutes of a program review meeting, a portion of a report developed for submission to a funding agency, an annual report, or other official description of the implementation of the strategy.	**2 examples** One of the examples must be from one of the two program areas from which documentation was provided in 2, above.	**5 years**

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STANDARD 3.1: Provide health education and health promotion policies, programs, processes, and interventions to support prevention and wellness.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.1.3 A Efforts to specifically address factors that contribute to specific populations' higher health risks and poorer health outcomes	The purpose of this measure is to assess the health department's assessment, identification, and efforts to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequities.	Differences in populations' health outcomes are well documented. Factors that contribute to these differences are many and varied and include the lack of opportunities and resources, economic and political policies, discrimination, and other aspects of a community that impact on individuals' and population's resilience. These differences in health outcomes cannot be effectively addressed with programs and interventions; they require engagement of the community in strategies that develop community resources, capacity, and strength.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Identification and implementation of strategies to address factors that contribute to specific populations' higher health risks and poorer health outcomes, or health inequity, including: a. Analysis of factors that contribute to higher health risks and poorer health outcomes of specific populations and the development of health equity indicators	**1. The health department must document efforts to address health equity among the populations in the health department's jurisdiction.** The health department must provide: a. The analysis of health inequity, factors that cause or contribute to it, and health equity indicators across communities or neighborhoods. Health equity indicators must be specific to the factors analyzed. Factors could be, for example, tax policies, community zoning, public education, transportation policy, and resource allocation.	**2 examples**	**5 years**

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	Indicators identified could be, for example, living standards, foreclosure rates, housing stock, transportation, safety, air quality, infrastructure (sewage, sidewalks, street design, etc.), employment and income levels, parks, and food access. Documentation of indicators would be the list of indicators identified. Documentation could be, for example, the results of an analysis in a report, white paper, briefing paper, or a memo.		
b. Public health efforts to address identified community factors that contribute to specific populations' higher health risks and poorer health outcomes and to impact health equity indicators	b. Plans and/or of efforts to address social change, social customs, community policy, level of community resilience, or the community environment to impact on health inequities. For example, the question "How do we motivate people to stop smoking?" can be rephrased as "What are the community conditions (e.g., stress, convenience stores, social norms) that encourage smoking?" Plans address the issue as defined as a community issue that impacts on higher health risks and poorer health outcomes of specific populations. Plans and/or reports will address efforts to work with those who set policy and make other decisions that impact the community's health inequities. Documentation could be, for example, program plans, program goals and objectives, reports, or other written commitment to address the factors in 1a, above. Reports could be, for example, press releases, formal reports to governance and/or the community, or other written document that outlines efforts to be made or achievements.		
c. Internal policies and procedures to ensure programs address specific populations at higher risk for poor health outcomes	c. Internal policies and procedures for the inclusion of health equity considerations of specific populations (for example, racial/ethnic minorities, those who live in poverty, and people with disabilities), in program development (e.g., RFPs or program proposals or plans).		

STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

Health departments must have processes and procedures for communicating with external audiences. Processes and procedures should address both accessing information from outside sources and communicating to people outside of the department. Effective public health communication requires a variety of methods and formats. Health departments should communicate with the public about their products and services, regulatory and policy activities, role in the community, and the value the departments deliver to the community. Also included are plans to communicate information to the public in times of calm and crisis, disasters, outbreaks, or other threats to the public's health.

STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.1 A Information on public health mission, roles, processes, programs, and interventions to improve the public's health provided to the public	The purpose of this measure is to assess the health department's efforts to inform the public and stakeholders about the role and value of public health and the range of services and programs that the health department provides.	Public health means different things to different people at various times. Conveying the value, mission, roles, processes, programs, and interventions of the health department is a necessary step in building effective public health programs and ensuring sustained funding levels.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of information provided to the public about what public health is, its value, and/or on the health department's roles, processes, programs, and interventions	**1. The health department must document the distribution of information to the public about the role and value of public health and/or the health department's role, mission, and scope of processes, programs and interventions.** The documentation must describe how the information was distributed, dates of distribution (or range of dates), and the purpose of the information. Documentation could be, for example, a copy of a presentation, advertisements or newspaper inserts, web posting, email or fax list-serve, fax cover sheet, brochure, services directory, or program flyers. The Tribal attorney may need to be included when crafting messages for the public and public health partners, especially for situations involving Tribal sovereignty, land and mineral disputes, or interactions with other local and federal government entities. Evidence of Tribal attorney use is acceptable documentation for items listed above, as appropriate.	**2 examples**	**5 years**

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2. Relationship with the media to ensure their understanding of public health and to ensure that they cover important public health issues	**2. The health department must document communication with the media.** The media include print media, radio, television, bloggers, web reporters, and diverse media outlets (for example, urban radio stations; free community newspapers; migrant worker newspapers; immigrant, ethnically targeted, and non-English language newspapers or radio stations, etc.) Documentation could be, for example, a log of media contacts, a published editorial concerning a public health issue (written by a department staff person or member of the governing entity), an appearance on a television show (of a department staff person or member of the governing entity), or a radio interview (of a department staff person or member of the governing entity), minutes or other documentation of a meeting or phone call with editorial staff, and emails or other communications with bloggers.	**2 examples**	**2 years**

STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.2 A Organizational branding strategy	The purpose of this measure is to assess the health department's strategy to communicate the value of its products, services, and practices to external audiences.	Branding is a standard business practice to raise the visibility, perceived value, and reputation of an organization. Branding communicates what the health department stands for and what it provides that is unique and differentiated from other agencies and organizations. Branding can help to position the health department as a valued, effective, trusted leader in the community.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A department brand strategy	**1. The health department must provide a brand strategy that includes provisions or steps to:** a. ensure that department staff have a clear understanding and commitment to the brand of the health department, b. communicate the health department's brand in a targeted manner (customized to different stakeholders) to convey the presence of the health department and the essential products and services that it delivers to its community, c. integrate brand messaging into organizational communication strategies and external communications (e.g., website, media releases, public service announcements, social media activities, speeches, grant applications, and promotional materials), d. use a common visual identity (logo) to communicate the health department's brand, e. display appropriate signage inside and outside the health department facility, and f. link the branding strategy to the department's strategic plan. Documentation could be, for example, written health department policies, plan, or strategies or could be a separate branding strategic document.	**1 policy, plan, or set of policies or strategies**	**5 years**

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2. Implementation of the department's branding strategy	**2. The health department must document its implementation of elements of its branding strategy.** Examples must implement plans, policies, or strategies as presented above.	**2 examples**	**5 years**

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STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.3 A Communication procedures to provide information outside the health department	The purpose of this measure is to assess the health department's written procedures for communication to the public, partners, and stakeholders.	Written procedures and protocols that are put into practice ensure consistency in the management of communications on public health issues. Such measures also ensure that the information is in an appropriate format to reach target sectors or audiences. This includes responding to requests for information or materials that the health department distributes in its jurisdiction. Departments should answer information requests in a timely and appropriate fashion and should obtain appropriate reviews and approvals of information they disseminate.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Procedures for communications that include: a. Dissemination of accurate, timely, and appropriate information for different audiences b. Coordination with community partners for the communication of targeted and unified public health messages	**1. The health department must provide a copy of communication procedures.** There is no required format for the procedures. The procedures must: a. Describe the process for disseminating information accurately, timely, and appropriately. The procedures must define the process for different audiences who may request or receive information from the health department. b. Describe the process for informing and/or coordinating with community partners to promote the dissemination of consistent and unified public health messages that are accurate and appropriate for the audience.	**1 procedure or one set of procedures**	**2 years**

c. A contact list of media and key stakeholders	c. Include a contact list of media and key stakeholders related to the protocol; set forth when the contact list is to be used; and include the process for maintaining the contact list.		
d. A designated staff position as the public information officer	d. Identify which department staff position is designated as the public information officer. The protocol must define this position's responsibilities, which must include: maintaining media relationships; creating appropriate, effective public health messages; and managing other communications activities. Documentation could be, for example, a job description or other description of responsibilities.		
e. Responsibilities and expectations for positions interacting with the news media and the public, including, as appropriate, any governing entity members and any department staff member	e. Describe the responsibilities for all staff positions that may interact with the news media and the public. This may include guidance for specific staff positions, such as the director, public information officer, and representatives of the governing entity.		
2. Implementation of communications procedures	**2. The health department must document the department's implementation of the communications procedures listed in 1, above.** The health department must provide public health messages disseminated outside the health department. Documentation could be a press release, email between the public information officer and the media, or other written communication to the media.	**2 examples** Examples must come from two different program areas, one of which is a chronic disease program.	**2 years**

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STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.4 A Risk communication plan	The purpose of this measure is to assess the health department's plans for risk communication during a crisis, disaster, outbreak, or other threat. The goal is to ensure an accurate understanding of the actual and perceived public health risks, the possible solutions, and related issues and concerns voiced by experts and non-experts.	The purpose of the risk communication plan is to detail the communications and media protocols the health department will follow during a public health crisis or emergency. The risk communication plan outlines the decisions and activities that will be taken for a timely, effective response. The plan will detail public relations processes and give guidance on anticipating a crisis and responding effectively. It should also address how to prevent public alarm by dealing appropriately with misconceptions or misinformation.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Risk communication plan	**1. The health department must provide a copy of the risk communication plan, protocol, or procedures.** The plan must provide protocols that address how information is provided for a given situation; address how information is provided 24/7; delineate roles, responsibilities and chain of command; describe how information will be disseminated in the case of communication technology disruption; address how message clearance will be expedited; and describe how the health department will work with the media. The plan must also address preventing public alarm by dealing with misconceptions or misinformation. There is no required format for the plan; that is, it may be a part of a larger communications plan or part of an overall department emergency operations plan. A risk communication plan may be identified, for example, as an emergency communication plan, crisis communication policies, risk communication plan, or media communication plan..	**1 plan**	**5 years**

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	For Tribal health departments, documentation may include referencing an existing, approved Tribal policy that identifies another Tribal employee or program (such as the Tribal emergency management planner) as being responsible for the risk communication plan and its implementation. For smaller Tribal health departments and programs, this measure could also be met with a written MOU or MOA with an external agency, such as a local health department, with clearly delineated roles for Tribal and non-Tribal staff and elected officials involved in the plan.		

STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.5 A Information available to the public through a variety of methods	The purpose of this measure is to assess the health department's use of a variety of methods and formats to keep the public informed about public health and environmental public health issues, health status, public health laws, health programs, and other public health information.	Health departments need the ability to present information to different audiences through a variety of methods, including information technology.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A website or web page that contains information on: a. 24/7 contact number for reporting health emergencies b. Notifiable/reportable conditions link or contact number c. Health data d. Links to public health-related laws e. Information and materials from program activities	**1. The health department must document that its website provides:** a. A 24/7 contact number for reporting health emergencies; b. Notifiable/reportable conditions line or contact number; c. Health data, for example, morbidity and mortality data; d. Links to public health related laws or public health code; e. Information and materials from program activities, for example, infectious disease, chronic diseases, environmental public health, prevention, and health promotion;	**1 website**	**2 years**

f. Links to CDC and other public health-related federal, state, or local agencies, as appropriate **g. The names of the health department's leadership**	f. Links to CDC and other public health-related federal, state, or local agencies, as appropriate; and g. The names of the health department director and the leadership team. The health department may have its own website or be part of another governmental website or internet domain. Documentation could be screen shots of the pages that contain the information required in each of the elements listed.		
2. Other communication strategies for informing the public about public health issues or functions	**1. The health department must document the use of other methods used to make information available to the general public about public health issues and/or functions.** Methods could include, for example, radio or television programs or interviews, brochures, flyers, newsletters, or digital media, Facebook or Twitter.	**2 examples**	**5 years**

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STANDARD 3.2: Provide information on public health issues and public health functions through multiple methods to a variety of audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 3.2.6 A Accessible, accurate, actionable, and current information provided in culturally sensitive and linguistically appropriate formats for target populations served by the health department	The purpose of this measure is to assess the health department's ability to convey public health information to the population it serves, including those who are hard to reach or who present language or cultural challenges.	Public health information must be understandable and usable by the target audience. Information should be accessible to all audiences in the jurisdiction served, whether they are non-English speaking, are hearing impaired, or have low literacy.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Demographic data regarding ethnicity and languages spoken in the community	**1. The health department must provide demographic data defining the ethnic distribution and languages spoken in the jurisdiction served.**	**1 data report or multiple data sets**	**2 years**
2. Interpretation, translation, or other specific communication services	**2. The health department must provide a list of staff or contractors who provide interpretation, translation, or specific communication services.** Specific communication services may mean non-English speaking or low literacy or hearing impaired communications. These services are provided as needed, based on demographic data. The services do not have to be provided directly by the health department, but must be available when needed. Tribal health departments may have "Indian preference" policies that demonstrate the promotion of culturally appropriate interactions between staff and community members. CHRs or "Cultural Interpreters" may also be available to provide both translation and feedback from community members on program materials or services provided.	**1 list**	**5 years**

3. Assistive staff or technology devices	**3. The health department must document assistance for the hearing or the visually impaired, or other assistive staff or technology devices.**	**1 example of assistive staff or devices**	**5 years**
4. Public health materials that are culturally appropriate, in other languages, at low reading level, and/ or address a specific population that may have difficulty with the receipt or understanding of public health communications	**4. The health department must provide materials that are appropriate for a population who may have difficulty with the receipt or understanding of public health communications.** Methods that target low-literacy individuals could include, for example, audio-visual formats and/or written materials that include images to support text. Documentation could be, for example, materials that are culturally or linguistically appropriate, or communicated for the hearing impaired. National Standards for Culturally and Linguistically Appropriate Services in Health and Healthcare is a resource for these efforts (http://thinkculturalhealth.hhs.gov/content/CLAS.asp)	**2 examples are required;** two examples must be from different program areas.	**2 years**

Domain 4: Engage with the Community to Identify and Address Health Problems

Domain 4 focuses on community engagement. Members of the community possess unique perspectives on how issues are manifested in the community, what and how community assets can be mobilized, and what interventions will be effective. Community members are important partners in identifying and defining public health issues, developing solutions or improvements, advocating for policy changes, communicating important information, and implementing public health initiatives. Public health can broaden its leverage and impact by doing things with the community rather than doing things to the community. Aligning and coordinating efforts towards health promotion, disease prevention, and health equity across a wide range of partners is essential to the success of health improvement. This domain addresses health departments' establishment and maintenance of community partnerships and collaborations that will facilitate public health goals being accomplished, promote community resilience, and advance the improvement of the public's health.

DOMAIN 4 INCLUDES TWO STANDARDS:

Standard 4.1:	Engage with the Public Health System and the Community in Identifying and Addressing Health Problems through Collaborative Processes
Standard 4.2:	Promote the Community's Understanding of and Support for Policies and Strategies that will Improve the Public's Health

STANDARD 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

Health improvement efforts will be most effective when the health department works with the community that it serves. Ongoing dialogue about community issues, discussions about options and alternatives, and community ownership increase the effectiveness of health improvement efforts. Collaboration with other members of the public health system and with members of the community develops shared responsibility and leads to better coordination of the use of resources. Collaboration provides the health department with various perspectives and additional expertise. Collaboration allows the community's assets to be mobilized, coordinated, and used in creative ways for increased community efficacy in addressing public health issues and concerns.

STANDARD 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 4.1.1 A Establishment and/or engagement and active participation in a comprehensive community health partnership and/or coalition; or active participation in several partnerships or coalitions to address specific public health issues or populations	The purpose of this measure is to assess the health department's engagement with partners in the public health system, representatives of various sectors of the community, and community members to address public health issues and concerns.	Community engagement is an ongoing process of dialogue and discussion, collective decisions, and shared ownership. Public health improvement requires social change; social change takes place when the population affected by the problem is involved in the solution. Collaborative partnerships to address public health issues and concerns provide various perspectives, additional expertise, and assets and resources. Partnerships provide the opportunity to leverage resources, coordinate activities, and employ community assets in new and effective ways. Collaborative partnerships include engagement with community members so that they are involved in the process and participate in the decisions made and actions taken. Community engagement also has benefits of strengthening social engagement, building social capital, establishing trust, ensuring accountability, and building community resilience.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Collaborative partnerships with others to address public health issues	**1. The health department must document a current, ongoing comprehensive community partnership or coalition in which it is an active member.** The purpose of the partnership or coalition must be to improve the health of the community and, therefore, must be engaged in various issues and initiatives. A comprehensive community partnership, in this context, is a partnership that is not topic or issue specific. It is a community partnership that addresses a wide range of community health issues. The comprehensive partnership or coalition may be organized into several committees or task forces to address specific issues, for example, teenage pregnancy, social determinants of health, health equity, or increased opportunities for physical activities. This partnership or coalition may be the same group that developed the community health assessment and community health improvement plan.	**1 broad community partnership or coalition addressing at least 4 health issues; or 4 examples of issue specific partnership or coalitions; or a mix of a partnership addressing 1 to 4 issues and single issue partnerships addressing the remaining number, for a total of four issues.**	**2 years**

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This partnership or coalition may work on various issues addressed in the Standards and Measure, such as access to care (Domain 7).

Alternatively, the health departments must document their involvement in several current ongoing partnerships or coalitions that address specific public health issues. In this case, each collaboration must address a particular public health issue or population. Examples of collaborative partnerships include: an anti-tobacco coalition, a maternal and child health coalition, an HIV/AIDS coalition, a childhood injury prevention partnership, child labor coalition, immigrant worker/community coalition, newborn screening advisory group, integrated chronic disease prevention coalition, and a partnership to decrease childhood obesity. Partnerships addressing issues that impact on health, for example, housing, transportation, or parks and recreation are acceptable.

Tribal public health departments may partner with other Tribal or local partners, for example, Head Start, emergency management, and social services to address specific Tribal health issues.

These partnerships and coalitions, whether a broad multi-issue partnership or a group of single issue partnerships or coalitions, may address an already established program area; newly identified issues; issues identified by the health assessment; strategies or actions included in a health improvement plan; a potential public health threat or hazard; populations with particular health needs; and/or goals of the community, health department, community, region, or state. They may address broad public health issues, for example, health equity or access to community resources. The partnerships or coalitions may also address issues that impact health, for example, smart growth and the built environment, education and training, employment rates, or transportation.

These partnerships or coalitions may be convened by the health department, by another organization, or by community members. The health department must actively participate. Examples must be from current, active partnerships and not partnerships that have completed their tasks and disbanded. Partnerships must include representation of the community impacted.

Documentation could be a summary or report of the partnership(s) or coalition(s), indicating on-going activities; meeting minutes and agendas: progress reports; evaluations, etc.

2. Partner organizations or representation	**2. The health department must provide a list of the participating partner organizations for the partnerships(s) or coalitions referenced above.** Organizational and representational membership must be listed; individuals' names are not required. For example, names of: the hospitals; school systems; and specific businesses, social service organizations, not-for-profit organizations, faith institutions, private citizen groups, or particular population groups. The membership must be broad and include various sectors of the community. Community members must be included.	**1 membership list of the broad community partnership or coalition; or lists of members of the 4 examples provided above in 4.1.1 RD 1**	**2 years**
3. Community, policy, or program change implemented through the partnership(s) or coalition(s)	**3. The health department must document a change in the community, a change in policy, or a new or revised program that was implemented through the work of the partnership(s) or coalition(s) identified in Required Documentation 1, above.** Examples could be an increase in the number and types of locations where tobacco use is not permitted, an increase in the number of miles of bike paths, a local zoning change, the removal of soda vending machines from public schools, an increase in the frequency of restaurant inspections, an increase in the number of community police stations, policies that address social determinants of health, etc.	**2 examples**	**5 years**

STANDARD 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 4.1.2 S Technical assistance provided to Tribal and local health departments and/or public health system partners regarding methods for engaging with the community	The purpose of this measure is to assess the state health department's provision of technical assistance to Tribal and local health departments and/or to public health system partners concerning methods of community engagement.	State health departments are a resource to Tribal and local health departments in the state and to public health system partners for information about engaging with the community.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provisions of consultation, technical assistance, and/or information concerning the use of models of community organizing or methods of community engagement provided to Tribal and local health departments and/or public health system partners	**1. The state health department must document the provision of consultation, technical assistance, and/or information to Tribal and local health departments or to public health system partners on use of methods for collaborative community engagement.** The state health department can provide this technical assistance directly, or through an established partner or contractor, such as a consultant or academic institution. Established methods of community engagement include but are not limited to: Healthy Cities/Communities methods; Asset Based Community Development; and deliberative processes, for example, regular town forums, community advisory groups, and participatory decision processes. Tools include the National Public Health Performance Standards Program (NPHPSP), asset mapping, community indicator projects, and Mobilizing for Action Through Planning and Partnership (MAPP). Other community organizing models and methods are acceptable. Documentation could be, for example, emails, newsletters, meeting minutes, web based assistance, agenda of meetings, documented phone calls, presentations, and training sessions.	**2 examples** If the state has a Tribal health department located in its jurisdiction, one of the examples must be related to a Tribal health department.	**5 years**

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STANDARD 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 4.1.2 T/L Stakeholders and partners linked to technical assistance regarding methods of engaging with the community	The purpose of this measure is to assess the Tribal or local health department's provision of sources of information about principles, processes, and methods of community engagement.	Tribal and local health departments are a community resource for partners and stakeholders who are seeking information about engaging with the community. Local health departments should be able to assist and link partners and stakeholders to resources for information on the principles, processes, and methods for engaging with the community.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of consultation, technical assistance, or information concerning methods of community engagement	**1. Tribal health departments and local health departments must document that consultation, technical assistance, or information is provided to community partners or stakeholders concerning methods for collaborative community engagement.** Tribal health departments may provide supporting documentation that they forward technical assistance requests to the state or a federal agency, for example, IHS, BIA, CDC or EPA, or that they work in partnership with state or local health departments, or other organizations/entities, such as an academic institution or consultant. Established methods of community engagement include but are not limited to: Healthy Cities/Communities methods; Asset Based Community Development; Mobilizing Action Toward Community Health (MATCH), and deliberative processes for example, regular town forums, community advisory groups, and participatory decision processes. Tools include asset mapping, community indicator projects, and Mobilizing for Action Through Planning and Partnership (MAPP). Documentation could be, for example, emails, newsletters, meeting minutes, web based assistance, agenda of meetings, documented phone calls, presentations, or training sessions that provide information about community engagement principles, processes, and/or models.	**2 examples**	**5 years**

STANDARD 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health.

Community understanding and support is critical to the implementation of public health policies and strategies. Community input and support is an important public health tool in developing and implementing policies and strategies. It is important to gain community input to ensure that a policy or strategy is appropriate, feasible, and effective.

STANDARD 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 4.2.1 A Engagement with the community about policies and/or strategies that will promote the public's health	The purpose of this measure is to assess the health department's engagement with the community on public health policies and strategies to promote the health of the population.	A health policy or strategy will more likely be strongly supported by the community if the community has engaged in a dialogue, discussed the options and alternatives, and taken ownership of the issue and the policy or strategy. Community engagement will encourage a sense of shared responsibility for the support and implementation of the policy or strategy.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Engagement of members of the specific community or group that will be affected by a policy and/or strategy to promote the public's health	**1. The health department must document engagement with the specific population in the community that will be affected by a policy or strategy.** The efforts can target the community as a whole (if the policy or strategy is community-wide) or it can target a specific group that will be most affected by a policy or strategy. Listening sessions, open forums, and other methods of dialogue can be used to develop engagement and community ownership. Documentation could be, for example, an announcement or minutes of a town meeting or public hearing, or a call for review and input posted through groups' customary communication channels such as newspapers and newsletters. Other examples include meetings with a particular geographic community served by the health department or a particular group of people, for example, adolescents, single mothers, or seniors.	**2 examples from different policy areas**	**2 years**

STANDARD 4.2: Promote the community's understanding of and support for policies and strategies that will improve the public's health.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 4.2.2 A Engagement with governing entities, advisory boards, and elected officials about policies and/or strategies that will promote the public's health	The purpose of this measure is to assess the health department's efforts to engage with governing entities, advisory boards, and elected officials whose policy decisions, advice, or strategies affect public health actions.	Health department policies and strategies will more likely be endorsed and supported by governing entities, advisory boards, and elected officials if they have been informed, engaged, and consulted during the decision-making process.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Engagement with the governing entity, advisory boards, and/or elected officials about policies and/or strategies that will promote the public's health	**1. The health department must document that it communicates and collaborates with the governing entity, an advisory board, and/or elected officials concerning public health policy or strategy.** Documentation could be, for example, a copy of a presentation, meeting packet, meeting agenda, meeting minutes, press story, event summary, briefing paper, or written public comments. Tribal documentation could be, for example, reports and/or meeting minutes from Health Oversight Committees and Tribal Council meetings, and Tribal and non-Tribal media coverage, including Tribal radio, newspapers, or newsletters.	**2 examples;** examples must address two separate public health issues	**2 years**

Domain 5: Develop Public Health Policies and Plans

Domain 5 focuses on the development of public health policies and plans. Written policies and plans serve as tools to guide the health department's work and bring structure and organization to the department. Written policies and plans provide a resource to health department staff as well as to the public. Policies and plans help to orient and train staff, inform the public and partners, and serve as a key component of developing consistency in operations and noting areas for improvement. The development of policies and plans can be a vehicle for community engagement and shared responsibility for addressing population health improvement.

Policies and plans that are not public health specific may also impact the public's health, for example, zoning, transportation, and education. Policy makers should be informed of the potential public health impact of policies that they are considering or that are already in place. Policy makers and the public should have access to sound, science-based, current public health information when policies are being considered or adopted.

DOMAIN 5 INCLUDES FOUR STANDARDS:

Standard 5.1:	Serve as a Primary and Expert Resource for Establishing and Maintaining Public Health Policies, Practices, and Capacity
Standard 5.2:	Conduct a Comprehensive Planning Process Resulting in a Tribal/State/Community Health Improvement Plan
Standard 5.3:	Develop and Implement a Health Department Organizational Strategic Plan
Standard 5.4:	Maintain an All Hazards Emergency Operations Plan

STANDARD 5.1: Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.

Health departments possess knowledge and expertise on current public health science, evidence-based interventions, and promising practices that are required to develop sound public health policies, practices, and capacities. Health departments also have access to community and population data and information that provide knowledge concerning the potential or current impact of policies, practices, and capacities. For these reasons, health departments should play a central and active role in the establishment of policies and practices, whenever governing entities, elected officials, governmental departments, and others set policies and practices that have public health implications.

Standard 5.1: Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.1.1 A The monitoring and tracking of public health issues that are being discussed by individuals and entities that set policies and practices that impact on public health	The purpose of this measure is to assess the health department's ability to maintain knowledge about what policies are being considered in order to ensure that the health department is in a position to influence the development of those policies and their impact on public health.	An important role for health departments is influencing the adoption of effective public health policies and practices by being a resource for science-based public health information. Health departments need to be constantly aware of what issues are being discussed by those who set policies and practices so that they can exert influence.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Monitoring/tracking of policies under consideration by the governing entity, elected officials, government officials, and/or other entities that set policies and practices that impact public health	**1. The health department must document that the department stays informed of the public issues that are being discussed by the health department's governing entity, and by elected officials, individuals, and/or other entities that set policies and practices that impact on the health department or public health.** Local elected officials include county (for example, county manager, board of commissioners, or supervisors) or city officials (for example, mayor, city council, board of commissioners, or supervisors). State elected officials include the governor, council of state, or state legislators. Tribal elected or appointed officials vary depending on the Tribal Nation's governance. Some examples include: Principal Chief, Chief, President, Chairman/woman/person, Governor, Tribal Council Member, or Health Oversight Committees. Government officials include elected or appointed positions or other staff of government departments (e.g., education, labor, insurance, etc.). Policies being discussed could be Tribal. State, or local policies. Documentation could be, for example, meeting minutes and agendas; a log of legislation impacting on health and environmental public health; health department membership on a list-serve that discusses public health issues; or newsletters, reports, or summaries showing health department review and tracking of issues discussed by elected officials or governing entities.	**2 examples**	**2 years**

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Standard 5.1: Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.1.2 A Engagement in activities that contribute to the development and/or modification of policy that impacts public health	The purpose of this measure is to assess the Tribal, state, or local health department's efforts to contribute to and influence the development and/or modification of Tribal, state, or local policies that impact public health.	To ensure that public health policies and practices are effective, health departments must be actively engaged in the development and/or modification of policies. The health department can provide policy makers with sound, science-based, current public health information that should be considered in setting policies and practice.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Contribution to deliberations concerning public policy	**1. The health department must document that it has contributed to deliberations concerning public policy and practice and its impact on public health.** The health department must engage with those who set policies, as well as with other stakeholders who can influence those who set policies. The health department can also contribute to and encourage stakeholder or community involvement in development and/or modification of public health related policy. The two examples must address two different items of the items listed below: • Informational materials, for example, issue briefs, media statements, talking points, fact sheets, white papers, and other official written documents. • Health department staff providing official department public testimony. • Health department staff participation in an advisory or work group appointed by the governing entity, elected officials, or the health department director. The group must have a stated purpose or intent of providing advice or influencing health policy. This does not have to be the only role of the group, but may be one among many responsibilities assigned.	**2 examples** Each example must address one item listed in the guidance. The two examples must address different items.	**2 years**

Standard 5.1: Serve as a primary and expert resource for establishing and maintaining public health policies, practices, and capacity.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.1.3 A Informed governing entities, elected officials, and/or the public of potential intended or unintended public health impacts from current and/or proposed policies	The purpose of this measure is to assess the health department's provision of information about the intended or unintended public health impacts of proposed or current public policies.	The health department is responsible for informing others of the potential public health impact of policies that they are considering or that are in place. Policies that are not health specific may impact the public's health. Health departments should provide policy makers and the public with sound, science-based, current public health information that should be considered in setting or supporting policies.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Information provided to policy makers and/or the public about potential public health impacts of policies that are being considered or are in place	**1. The health department must document that it has informed policy makers and/or the public about potential public health impacts of policies that are being considered or are in place.** Included may be policies that impact public health but are developed by other sectors, for example, land use, housing, employment, transportation, and education. The health department may address both intended and unintended impact. Documentation can address policies either in effect or proposed. Each example must address one of the items listed below must be addressed: • Impact statement or fact sheet that addresses current or proposed policies. The impact statements must be science-based. The health department must show to whom the statement or fact sheet was distributed. • The distribution of correspondence, emails, briefing statements, or reports on policy impacts. If there is a discussion of policy issues and impacts, the documentation must include who in the health department participated, who was invited to participate, participant listing, what was discussed, meeting materials or agenda, and any follow- up to be completed. • A presentation of evaluations or assessments of current and/or proposed policies. The presentation or the evaluation/assessment report and an agenda for the presentation.	**2 examples** Examples must address different items listed in the Guidance.	**2 years**

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STANDARD 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

The Tribal, state, or community health improvement plan is a long-term, systematic plan to address issues identified in the Tribal, state, or community health assessment. The purpose of the community health improvement plan is to describe how the health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves. The community, stakeholders, and partners can use a solid community health improvement plan to set priorities, direct the use of resources, and develop and implement projects, programs, and policies.

The plan is more comprehensive than the roles and responsibilities of the health department alone, and the plan's development must include participation of a broad set of community stakeholders and partners. The planning and implementation process is community-driven. The plan reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

The state health department's state health improvement plan addresses the needs of all citizens in the state. The local health department's community health improvement plan addresses the needs of the citizens within the jurisdiction it serves. The Tribal health department's Tribal health improvement plan addresses the needs of the Tribal population residing within the Tribe's jurisdictional area.

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.1 S A process to develop a state health improvement plan	The purpose of this measure is to assess the state health department's collaborative community health improvement planning process and the participation of stakeholders.	While the state health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other agencies and organizations to plan and share responsibility for health improvement. Other sectors of the state and stakeholders have access to additional data and bring different perspectives that will enhance planning. A collaborative planning process fosters shared ownership and responsibility for the plan's implementation. The state health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. State health improvement planning process that included:	**1. The state health department must document the collaborative state health improvement planning process.** The process may be a national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, State Health Improvement Plan (SHIP) Guidance and Resources (http://www.astho.org/accreditation/SHIP/), Mobilizing for Action through Planning and Partnerships (MAPP) (developed for local health departments but can be used in state health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4), and the University of Kansas Community Toolbox (http://ctb.ku.edu/en/node/9). Examples of tools or resources that can be adapted or used include Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.	**1 process**	**5 years**

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	The state health department must document that the state health improvement planning process included all of the following:		
a. Broad participation of community partners	a. Participation by a wide range of community partners representing various sectors of the community. Partners are organizations that work with the state health department on health issues and could include other governmental agencies, statewide not-for-profit groups, statewide associations, veterinarian organizations, and others, including organizations that are not health-specific, for example, education advocates, businesses, recreation organizations, faith-based organizations, etc. Members of this group may or may not be the same as members of the community health assessment partnership. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees.		
b. Information from community health assessments	b. Data and information from the community health assessment provided to participants in the state health improvement planning process to use in their deliberations. This may include a list of data sets or evidence that participants used for the community health assessment.		
c. Issues and themes identified by stakeholders in the community	c. Evidence that stakeholder discussions were held and that they identified issues and themes. The list of issues must be provided as documentation.		
d. Identification of assets and resource	d. Assets and resources identified and considered in the state health improvement planning process. Community assets and resources could be anything that the state could utilize to improve the health of the community. Community assets and resources could include, for example, skills of residents, the power of state associations (e.g., service associations, professional associations) and institutions (e.g., faith based organizations, foundations, institutions of higher learning), as well as other state factors for example, state recreational facilities, social capital, community resilience, a strong business community, etc. Assets and resources can be documented in a list, chart, narrative description, etc.		
e. A process to set health priorities	e. A description of the process used by participants to develop a set of priority state health issues		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.1 L A process to develop a community health improvement plan	The purpose of this measure is to assess the local health department's collaborative community health improvement process and the participation of stakeholders.	While the local health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other sectors and organizations to plan and share responsibility for community health improvement. Other sectors of the community and stakeholders have access to additional data and bring different perspectives that will enhance planning. A collaborative planning process fosters shared ownership and responsibility for the plan's implementation. The community health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Community health improvement planning process that included:	**1. The local health department must document the collaborative community health improvement planning process.** The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4), and the University of Kansas Community Toolbox (http://ctb.ku.edu/en/node/9). Examples of tools or resources that can be adapted or used include NACCHO's Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.	**1 process**	**5 years**

	The local health department must document that the community health improvement planning process included all of the following:		
a. Broad participation of community partners	a. Participation by a wide range of community partners representing various sectors of the community. Community partners could include, as appropriate for the specific community: hospitals and healthcare providers, the faith community, veterinarians, military installations, academic institutions, local schools, other departments of government (e.g., parks and recreation, planning and zoning, housing and community development, etc.), economic development, community not-for-profits, civic groups, elected officials, the chamber of commerce and local businesses, police, housing, foundations and philanthropists, planning organizations, and the state health department. Members of this group may or may not be the same as members of the community health assessment partnership. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists for work groups or subcommittees.		
b. Information from community health assessments	b. Data and information from the community health assessment provided to participants in the community health improvement planning process for use in their deliberations. This may include a list of data sets or evidence that participants used the community health assessment.		
c. Issues and themes identified by stakeholders in the community	c. Evidence that community and stakeholder discussions were held and that they identified issues and themes. Community members' definition of health and of a healthy community must be included. The list of issues identified by the community and stakeholders must be provided as documentation.		
d. Identification of community assets and resources	d. Community assets and resources identified and considered in the community health improvement process. Community assets and resources could be anything in the community that could be utilized to improve the health of the community. Community assets and resources could include, for example, skills of residents, the power of local associations (e.g., service associations, professional associations) and local institutions (e.g., faith based organizations, local foundations, institutions of higher learning), as well as other community factors for example, parks, social capital, community resilience, a strong business community, etc. Community assets and resources can be documented in a list, chart, narrative description, etc.		
e. A process to set health priorities	e. A description of the process used by participants to develop a set of priority health issues.		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.1 T A process to develop a Tribal community health improvement plan	The purpose of this measure is to assess the Tribal health department's collaborative community health improvement planning process and the participation of stakeholders.	While the Tribal health department is responsible for protecting and promoting the health of the population, it cannot be effective acting unilaterally. The health department must partner with other sectors and organizations to plan and share the responsibility for health improvement. Other sectors of the community and stakeholders have access to additional data and bring different perspectives that will enhance planning. A collaborative planning process fosters shared ownership and responsibility for the plan's implementation. The community health improvement process is a vehicle for developing partnerships and for understanding roles and responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Tribal community health improvement planning process that included:	**1. The Tribal health department must document the collaborative community health improvement process.** The process used may be an accepted national model; state-based model; a model from the public, private, or business sector; or other participatory process model. When a specific model is not used, the key steps undertaken that outline the process used should be described. National models include, for example, Mobilizing for Action through Planning and Partnerships (MAPP) (developed for local health departments but can be used in Tribal health departments), Association for Community Health Improvement (ACHI) Assessment Toolkit, Assessing and Addressing Community Health Needs (Catholic Hospital Association of the US) (http://www.chausa.org/docs/default-source/general-files/cb_assessingaddressing-pdf.pdf?sfvrsn=4), and the University of Kansas Community Toolbox (http://ctb.ku.edu/en/node/9). Examples of tools or resources that can be adapted or used as part of the community health improvement planning process include NACCHO's Resource Center for Community Health Assessments and Community Health Improvement Plans, Community Indicators process project, Asset Based Community Development model, Tribal Accreditation Readiness Guidebook and Roadmap, Inter Tribal Council of Arizona's Tribal CHA Toolkit, National Public Health Performance Standards Program (NPHPSP), Assessment Protocol for Excellence in Public Health (APEX/PH), Guide to Community Preventive Services, and Healthy People 2020.	**1 process**	**5 years**

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	The Tribal health department must document that the Tribal health improvement planning process included all of the following:		
a. Broad participation of public health system partners	a. Participation by a wide range of community partners. Community partners could include, for example, organizations that work with the Tribal health department to address health issues and may include other governmental agencies, not-for-profit groups, associations, and others, including organizations that are not health-specific, for example, education advocates, businesses, recreation organizations, faith-based organizations, veterinarians, military installations, etc. Members of this group may or may not be the same as members of the community health assessment partnership. Documentation could be, for example, participant lists, attendance rosters, minutes, or membership lists of work groups or subcommittees.		
b. Information from Tribal health assessments	b. Data and information from the Tribal community health assessment that were provided to participants in the Tribal health improvement planning process to use in their deliberations. National data sources on American Indian/Alaska Native populations include Indian Health Service data and other sources. Documentation may include a list of data sets or evidence that participants used the community health assessment.		
c. Issues and themes identified by the stakeholders	c. Evidence that stakeholder discussions were held and that they identified issues and themes. Community members' definition of health and healthy community must be included. The list of issues must be provided as documentation.		
d. Identification of Tribal assets and resources	d. Assets and resources identified and considered in Tribal community health improvement planning process. Tribal community assets and resources could be anything in the community that could be utilized to improve the health of the community. Community assets and resources could include skills of residents, the power of community groups (e.g., council of elders, youth councils, health promotion coalitions of Tribal program) and local community partners (e.g., faith based organizations, schools, institutions of higher learning), as well as recreation centers, cultural celebrations and activities, other community factors for example, parks, social capital, community resilience, etc. Community assets and resources can be documented in a list, chart, narrative description, etc.		
e. A process to set Tribal health priorities	e. A description of the process used by participants to develop a set of priority Tribal health issues.		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.2 S State health improvement plan adopted as a result of the health improvement planning process	The purpose of this measure is to assess the state health department's state health improvement plan. While some or many programs in the state health department may have program specific plans, they do not fulfill the purpose of the state health improvement plan, which looks at population health across programs and across the state.	The state health improvement plan provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction. The plan reflects the results of a collaborative planning process that includes significant involvement by key sectors. Partners can use a state health improvement plan to prioritize existing activities and set new priorities. The plan can serve as the basis for taking collective action and can facilitate collaborations.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. State health improvement plan that includes: **a. Desired measurable outcomes or indicators of health improvement and priorities for action**	**1. The state health department must provide a state health improvement plan that includes all of the following:** a. The desired measurable outcomes or indicators of the health improvement effort and the priorities for action, from the perspective of the population of the state. The plan must include statewide health priorities, measurable objectives, improvement strategies, and activities with time-framed targets that were determined in the planning process. In establishing priorities, the plan must include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities. Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the state health improvement plan for this measure. Strategies may be evidence-based, practice-based, or promising practices or may be innovative to meet the needs of the population. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020) should be referenced, as appropriate.	**1 completed plan**	**5 years**

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b. Policy changes needed to accomplish health objectives	b. Policy changes needed to accomplish the identified health objectives must be included in the plan. Policy changes must include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, and zoning, for example.		
c. Individuals and organizations that have accepted responsibility for implementing strategies	c. Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the state health improvement plan. This may include assignments to staff or agreements between planning participants, stakeholders, other state governmental agencies, or other statewide organizations. For this measure, agreements do not need to be formal, such as an MOA/MOU.		
d. Consideration of Tribal, local, and national priorities	d. States must demonstrate that they considered both Tribal and local health department health improvement priorities. Consideration of national priority alignment could include using the National Prevention Strategy and Healthy People 2020.		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.2 L Community health improvement plan adopted as a result of the community health improvement planning process	The purpose of this measure is to assess the local health department's community health improvement plan. While some or many programs in the local health department may have program specific plans, they do not fulfill the purpose of the community health improvement plan, which looks at population health across programs and across the community.	The community health improvement plan provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction. The plan reflects the results of a collaborative planning process that includes significant involvement by key sectors. Partners can use a community health improvement plan to prioritize existing activities and set new priorities. The plan can serve as the basis for taking collective action and can facilitate collaboration.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Community health improvement plan that includes: a. Desired measurable outcomes or indicators of health improvement and priorities for action	**1. The local health department must provide a community health improvement plan that includes all of the following:** a. The desired measurable outcomes or indicators of the health improvement effort and priorities for action, from the perspective of community members. The plan must include community health priorities, measurable objectives, improvement strategies and activities with time-framed targets that were determined in the community planning process. In establishing priorities, the plan must include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities. Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the health improvement plan for this measure. Strategies may be evidence-based, practice-based, or promising practices or may be innovative to meet the needs of the community. National state-of-the-art guidance (for example, the National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020) should be referenced, as appropriate.	**1 plan**	**5 years**

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b. Policy changes needed to accomplish health objectives	b. Policy changes needed to accomplish the identified health objectives must be included in the plan. Policy changes must include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, access to recreational opportunities, and zoning, for example.		
c. Individuals and organizations that have accepted responsibility for implementing strategies	c. Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the community health improvement plan. This may include assignments to staff or agreements between planning participants, stakeholders, health care providers (community benefit), other local governmental agencies, or other community organizations. For this measure, agreements do not need to be formal, such as an MOA/MOU.		
d. Consideration of state and national priorities	d. Local health departments must demonstrate that they considered both national and state health improvement priorities where they have been established. National priority alignment could include the National Prevention Strategy and Healthy People 2020.		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.2 T Tribal community health improvement plan adopted as a result of the health improvement planning process	The purpose of this measure is to assess the Tribal health department's Tribal community health improvement plan. While some or many programs in the Tribal health department may have program specific plans, they do not fulfill the purpose of the Tribal community health improvement plan, which looks at population health across programs and throughout the Tribal jurisdiction or service area.	The Tribal community health improvement plan provides guidance to the health department, its partners, and stakeholders for improving the health of the population within the health department's jurisdiction. The plan reflects the results of a collaborative planning process that includes significant involvement by key sectors. Partners can use a health improvement plan to prioritize existing activities and set new priorities. The plan can serve as the basis for taking collective action and can facilitate collaboration.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Tribal health community improvement plan that includes: a. Desired outcomes of health improvement and priorities for action	**1. The Tribal health department must provide a Tribal community health improvement plan that includes all of the following:** a. The desired measurable outcomes or indicators of the community health improvement effort and priorities for action, from the perspective of the population of the Tribe. The plan must include Tribal health priorities, measurable objectives, improvement strategies, and activities with time-framed targets that were determined in the planning process. In establishing priorities, the plan must include consideration of addressing social determinants of health, causes of higher health risks and poorer health outcomes of specific populations, and health inequities. Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the health improvement plan for this measure. Strategies may be evidence-based, practice-based, promising practices, or may be innovative to meet the needs of the Tribe's population. Guidance (for example, National Prevention Strategy, Guide to Community Preventive Services, and Healthy People 2020) should be referenced, as appropriate.	**1 plan**	**5 years**

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b. Policy changes needed to accomplish health objectives	b. Policy changes needed to accomplish the identified health objectives must be included in the plan. Policy changes must include those that are adopted to alleviate the identified causes of health inequity. Policy changes may address the social and economic conditions that influence health equity including housing, transportation, education, job availability, neighborhood safety, access to recreational activities, and zoning, for example.		
c. Individuals and organizations that have accepted responsibility for implementing strategies	c. Designation of individuals and organizations that have accepted responsibility for implementing strategies outlined in the Tribal health improvement plan. This may include assignments to staff or agreements between planning participants, stakeholders, other governmental agencies, or other Tribal organizations. For this measure, agreements do not need to be formal and do not require compacts, contracts or an MOA/MOU.		
d. Consideration of local, state, and national priorities	d. Tribes must demonstrate that they considered state, local and national health improvement priorities. This could include the National Prevention Strategy and Healthy People 2020.		

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.3 A Elements and strategies of the health improvement plan implemented in partnership with others	The purpose of this measure is to assess the Tribal, state, or local health department's implementation of its community health improvement plan in partnership with others.	Any plan is useful only when it is implemented and provides guidance for activities and resource allocation.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A process to track actions taken to implement strategies in the community health improvement plan	**1. The health department must provide a tracking process of actions taken toward the implementation of the community health improvement plan.** The tracking process must specify the strategies being used, the responsible partners involved, and the status of the effort or results of the actions taken. Documentation could be, for example, a narrative, table, spread sheet, or a combination. This may look like a work plan that includes the status of the implementation of the work plan.	**1 report or a group of reports**	**5 years**
2. Implementation of the plan	**2. The health department must document areas of the plan that were implemented by the health department and/or its partners.** Examples must identify a specific achievement and describe how it was accomplished.	**2 examples**	**5 years**

Standard 5.2: Conduct a comprehensive planning process resulting in a Tribal/state/community health improvement plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.2.4 A Monitor and revise as needed, the strategies in the community health improvement plan in collaboration with broad participation from stakeholders and partners	The purpose of this measure is to assess the health department's efforts to ensure that the strategies of the community health improvement plan are assessed for feasibility and effectiveness and that they are revised as indicated by those assessments.	Effective, community health improvement plans are dynamic. While goals, objectives, and priorities are meant to be long range, strategies may need to be adjusted. Strategies may need revision based on a completed objective, an emerging health issue, a change in responsibilities, or a change in resources and assets. All identified tasks and timelines, should be monitored and assessed for progress, and adjustments should be made when indicated to ensure that the plan remains relevant. Changes should be developed in collaboration with partners and stakeholders involved in the planning process.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Report on progress made in implementing strategies in the community health improvement plan	**1. The health department must provide an annual report on the progress made in implementing strategies in the community health improvement plan.** The report will consider the feasibility and the effectiveness of the strategies and/or changing priorities, resources, or community assets. If the plan was adopted within the year, a report of a previous plan may be provided or detailed plans for assessment and reporting may be submitted.	**1 example**	**14 months**
2. Review and revision, as necessary, of the health improvement plan strategies based on results of the assessment	**2. The health department must document that the health improvement plan has been reviewed and revised as necessary based on the report required in 1 above.** The revisions may be in the improvement strategies, planned activities, time-frames, targets, or assigned responsibilities listed in the plan. Revisions may be based on, for example, achieved activities, implemented strategies, changing health status indicators, newly developing or identified health issues, and changing level of resources. If the plan was adopted less than a year before it was uploaded to PHAB, the health department may provide (1) revisions of an earlier plan or (2) detailed plans for a revision process.	**1 example**	**14 months**

STANDARD 5.3: Develop and implement a health department organizational strategic plan.

Strategic planning is a process for defining and determining an organization's roles, priorities, and direction over three to five years. A strategic plan sets forth what an organization plans to achieve, how it will achieve it, and how it will know if it has achieved it. The strategic plan provides a guide for making decisions on allocating resources and on taking action to pursue strategies and priorities. A health department's strategic plan focuses on the entire health department. Health department programs may have program-specific strategic plans that complement and support the health department's organizational strategic plan; this standard addresses the health department's organizational strategic plan.

Standard 5.3: Develop and implement a health department organizational strategic plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.3.1 A Department strategic planning process	The purpose of this measure is to assess the health department's strategic planning process.	A functional and useful organizational strategic plan requires that it be understood by staff and implemented by the health department. The development of such a plan requires a planning process that considers opinions and knowledge from across the health department, assesses the larger environment in which the health department operates, uses its organizational strengths and addresses its weaknesses, links to the health improvement plan that has been adopted by the community, and links to the health department's quality improvement plan.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Use a planning process to develop the organization's strategic plan:	**1. The health department must document the process that it used to develop its organizational strategic plan.** The planning process may have been facilitated by staff of the health department or by an outside consultant. If the health department is part of a super health agency or umbrella agency (see PHAB Acronyms and Glossary of Terms), the health department's process may have been part of a larger organizational planning process. If that is the case, the health department must have been actively engaged in the process and must provide evidence that public health was an integral component in the process.	**1 strategic planning process**	**5 years**
a. Membership of the strategic planning group	a. A list of the individuals who participated in the strategic planning process and their titles must be provided. Participants must include various levels of staff as well as representatives of the health department's governing entity. Documentation could be, for example, meeting minutes, a report that presents the members of a strategic planning committee, or other formal listing of participants.		
b. Strategic planning process steps	b. Documentation must include a summary or overview of the strategic planning process, including the number of meetings, duration of the planning process, and the methods used for the review of major elements by stakeholders. Steps in the planning process must be described, for example, opportunities and threats analysis or environmental scanning process, stakeholder analysis, story-boarding, strengths and weaknesses analysis, and scenario development.		

Standard 5.3: Develop and implement a health department organizational strategic plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.3.2 A Adopted department strategic plan	The purpose of this measure is to assess the health department's completion and adoption of a department strategic plan.	A strategic plan defines and determines the health department's roles, priorities, and direction over three to five years. A strategic plan sets forth what the department plans to achieve as an organization, how it will achieve it, and how it will know if it has achieved it. The strategic plan provides a guide for making decisions and allocating resources to pursue its strategies and priorities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Health department strategic plan that includes:	**1. The health department must provide a strategic plan.** If the health department is part of a super health agency or umbrella agency (see PHAB Acronyms and Glossary of Terms), the health department's strategic plan may be part of a larger organizational plan. If that is the case, the plan must include a section that addresses the health department and includes the required elements of the plan specific to the health department. Submitted documentation should include only the section(s) of the larger plan that addresses the health department and not the entire plan. If the plan of the super health agency or umbrella agency does not include the required elements for the health department, then the health department must document that it has conducted an internal health department planning process and adopted a health department specific strategic plan. Some health departments may have shorter planning timeframes and, for example, may produce a strategic plan every three years. Some of the goals in the plan may be for a longer time period than five years, but the plan must have been produced or revised within the last five years. There is no required or suggested format for the strategic plan. There is no required or suggested length of the strategic plan. The health department may call the plan something other than a "strategic plan," but it must include the items listed in a through g.	**1 strategic plan**	**5 years**

	The strategic plan must include all of the following:		
a. Mission, vision, guiding principles/ values	a. The health department's mission, vision, and guiding principles/values for the health department.		
b. Strategic priorities	b. The health department's strategic priorities.		
c. Goals and objectives with measurable and time-framed targets	c. The health department's goals and objectives with measurable and time-framed targets (expected products or results). Measurable and time-framed targets may be contained in another document, such as an annual work plan. If this is the case, the companion document must be provided with the strategic plan for this measure.		
d. Consideration of key support functions required for efficiency and effectiveness	d. The strategic plan must consider capacity for and enhancement of information management, workforce development, communication (including branding), and financial sustainability.		
e. Identification of external trends, events, or factors that may impact community health or the health department	e. The identification of external trends, events, or other factors that may impact community health or the health department.		
f. Assessment of health department strengths and weaknesses	f. The analysis of the department's strengths and challenges.		
g. Link to the health improvement plan and quality improvement plan	g. Linkages with the health improvement plan and the health department's quality improvement plan. The strategic plan need not link to all elements of the health improvement plan or quality improvement plan, but it must show where linkages are appropriate for effective planning and implementation.		

Standard 5.3: Develop and implement a health department organizational strategic plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.3.3 A Implemented department strategic plan	The purpose of this measure is to assess the health department's implementation of its strategic plan.	A plan is useful only when it is implemented and provides guidance for priorities, activities, and resource allocation. A strategic plan sets forth what the department plans to achieve as an organization, how it will achieve it, and how it will know if it has achieved it. It is important to regularly review the implementation of the plan to ensure that the department is on track to meet its targets.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Progress towards achievement of the goals and objectives contained in the plan	**1. The health department must provide reports developed since the plan's adoption showing that it has reviewed the strategic plan and has monitored and assessed progress towards reaching the goals and objectives.** The reports must include how the targets are monitored. Progress is evidenced by completing defined steps to reach a target, by completing objectives, or by addressing priorities and implementing activities. Reports must be completed no less frequently than annually. The plan may be revised based on work completed, adjustments to timelines, or changes in available resources. If the plan has been adopted within the year, progress reports of a previous plan may be provided or detailed evaluation plans may be submitted.	**2 reports**	**1 report dated within 14 months; second report may be older**

STANDARD 5.4: Maintain an all hazards emergency operations plan.

Health departments play important roles in preparing for and responding to disasters, including preventing the spread of disease, protecting against environmental public health hazards, preventing injuries, assisting communities in recovery, and assuring the quality and accessibility of health and health care services following a disaster. Disasters include: natural disasters (such as floods, earthquakes, and tornadoes), manmade or technological disasters (such as bridge or building collapses, nuclear accidents, and chemical releases), and terrorism (such as anthrax or other biological terrorism, chemical terrorism, radiological/nuclear terrorism, or bombings). Plans for responding to emergencies are critical to being prepared for effective public health action during disasters and similar emergency events and for building community resilience over time.

Standard 5.4: Maintain an all hazards emergency operations plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.4.1 A Process for the development and maintenance of an All Hazards Emergency Operations Plan (EOP)	The purpose of this measure is to assess the health department's collaborative activities to organize coordinated responses to emergencies.	Health departments play a central but not exclusive role in response to emergencies. It is critical to ensure effective coordination of many agencies and organizations involved in responding to emergencies, managing the many response and recovery activities, and building community resilience.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Collaborative planning with other government agencies	**1. The health department must document that it participates in preparedness meetings with other government agencies and other levels of health departments (Tribal, state, and local).** Documentation could be, for example, meeting agenda and minutes, meeting rosters, calendar of meetings, email exchanges, and phone calls, as shown on a log or other record.	**2 examples**	**5 years**
2. Collaborative testing of the All Hazards EOP: a. Description of a real emergency or exercise b. Debriefing or After-Action Report (AAR)	**2. The health department must document that it participates in drills, exercises, or actual implementation of the All Hazards Emergency Operations Plan in order to test its implementation.** a. The documentation may be of either an actual or a simulated emergency (drill or exercise). This description must include documentation of how the health department coordinated with emergency response partners during the emergency or drill/exercise. Emergency response partners may be Tribal, state, or local emergency services agencies, including law enforcement, or community partners, such as a hospital. Partners may also come from the Tribal, state or local planning committee. b. Documentation must include debriefing or evaluation reports from the emergency or drill/exercise. Examples could be an evaluation report, minutes from a debriefing session, or the AAR produced by the health department or a partner health department.	**2 examples**	**5 years**

3. Collaborative revision of the All Hazards EOP that includes:	**3. The health department must document collaboration in revising emergency plans including:**	**1 example**	**5 years**
a. A collaborative review meeting	a. A collaborative review of the All Hazards Emergency Operations Plan by those responsible for its implementation. Documentation could be, for example, meeting agendas and minutes or attendance rosters or other written report or record.		
b. Updated contact information	b. A contact list of responders. Documentation could be the most current contact list or previous listings that have been updated.		
c. Coordination with emergency response partners	c. The delineation of roles and responsibilities in the Emergency EOP and the various roles that partners play in responding to a public health emergency or hazard.		
d. Revised All Hazards/EOP	d. A copy of the revised emergency operations plan to document the result of the work to maintain the plan and ensure that it is up-to-date and reflects current practice and information. Updates must be indicated in some way (e.g., underlined) and the date of the change must be noted.		

Standard 5.4: Maintain an all hazards emergency operations plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.4.2 A Public health emergency operations plan (EOP)	The purpose of this measure is to assess the health department's development and maintenance of the emergency operations plan.	An emergency operations plan outlines core roles and responsibilities for all-hazard responses, as well as plans for scenario- specific events, such as hurricanes. Health departments must engage in basic activities to prepare for respond to emergencies. In addition to coordination and communication with other agencies and organizations, the health department should have a public health specific emergency operations plan to work with the community in an emergency for the community's sustained ability to withstand and recover from an emergency event.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. EOP, as defined by Tribal, state, or national guidelines that includes:	**1. The health department must provide its public health emergency operations plan.** The plan must be written as defined by national, Tribal, or state guidelines. The guidelines may be defined for local health departments by the state health department or may be defined for both state and locals by a Federal or another state agency, such as an office of emergency management. Project Public Health Ready (PPHR) is a national model that could be used. Tribes may use guidelines that are most appropriate for their unique emergency management needs. The plan may be a standalone document that delineates the health department's roles and responsibilities, or it may be a section within a larger plan. The plan must address emergency operations for the entire population (including special needs and vulnerable populations, e.g., those with disabilities and non-English speaking people). The public health EOP must include all of the following:	**1 EOP**	**5 years**

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a. Designation of the health department staff position that is assigned the emergency operations coordinator responsibilities	a. The health department staff position responsible for coordinating a response within the department in an emergency. This position may have various job titles.		
b. Roles and responsibilities of the health department and its partners	b. The roles and responsibilities of the health department and its partners.		
c. Communication networks or communication plan	c. A health department communication network that addresses communication with other members of emergency networks or organizations that are also responders; or an emergency communication plan. The plan may be a separate plan, a defined section within the emergency operations plan, or it may be incorporated within the emergency operations plan.		
d. Continuity of operations	d. Description of how the health department will manage continuity of operations during an emergency.		
2. Testing of the public health EOP, through the use of drills and exercises	**2. The health department must document that the plan has been reviewed or tested through the use of exercises and drills, and revised as needed and must include:**	**2 examples**	**5 years**
a. Process for exercising and evaluating the public health EOP	a. A description of the process for testing and evaluating the Emergency Operations Plan. Documentation could be, for example, a written procedure, a memo stating the process, meeting minutes that document the procedure, or other written report or record.		
b. After-Action Report (AAR)	b. An After-Action Report (AAR) developed after an emergency or exercise/drill.		

3. Revision of the public health EOP including: a. A review meeting b. Revised public health EOP, as needed	**3. The health department must document that the public health emergency operations plan has been revised as indicated by review of the AAR.** a. Documentation of a review meeting. Documentation could be, for example, meeting minutes, a list of items discussed, a memo documenting review and decisions, or other written report or record. b. A public health EOP that has been revised as indicated through review, evaluation, and/or drills.	**1 example**	**2 years**

Standard 5.4: Maintain an all hazards emergency operations plan.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 5.4.3 S Consultation and/or technical assistance provided to Tribal and local health departments in the state regarding evidence-based and/or promising practices/templates in EOP development and testing	The purpose of this measure is to assess the state health department's support of Tribal and local health departments in the state in preparing for response to emergency situations and the development of an EOP.	State health departments are ultimately responsible for ensuring adequate response to public health emergencies. Tribal and local health departments are partners in providing a public health response to an emergency. State health departments are in a position to share communications and information received from the federal level and to share information concerning the state's EOP to ensure optimal coordination.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of consultation and/or technical assistance	**1. The state health department must document the provision of expert consultation, advice, and /or information provided to Tribal or local health departments concerning the development and testing of emergency operations plans.** Documentation could be, for example, blast faxes, webinars, emails, briefing papers, meeting minutes, distributed sample protocols, newsletters, trainings, conference calls, and documented phone calls.	**2 examples**	**5 years**

Domain 6: Enforce Public Health Laws

Domain 6 focuses on the role of public health departments in the enforcement of public health related regulations, executive orders, statutes, and other types of public health laws. Public health laws are key tools for health departments as they work to promote and protect the health of the population. Health department responsibilities related to public health laws do not start or stop with enforcement. Health departments also have a role in promoting new laws or revising existing laws. Public health related laws should be science-based and protect the rights of the individual, as they also protect and promote the health of the population. Health departments have a role in educating regulated entities about the meaning, purpose, compliance requirements, and benefit of public health laws. Health departments also have a role in educating the public about laws and the importance of complying with them.

The term "laws" as used in these standards and measures refers to ALL types of statutes, regulations, rules, executive orders, ordinances, case law, and codes that are applicable to the jurisdiction of the health department. For state health departments, not all ordinances are applicable, and therefore ordinances may not need to be addressed by state health departments. Similarly, some statutes are not applicable to local health departments, and therefore some statutes may not need to be addressed by local health departments. For Tribal health departments, applicable "laws" will depend on several factors, including governance framework and interaction with external governmental entities (federal, state, and local).

Public health laws include such areas as environmental public health (food sanitation, lead inspection, drinking water treatment, clean air, waste-water disposal, and animal and vector control), infectious disease (outbreak investigation, required newborn screenings, immunizations, infectious disease reporting requirements, quarantine, tuberculosis enforcement, and STD contact tracing), chronic disease (sales of tobacco products to youth, smoke-free ordinances, and adoption of bike lanes), and injury prevention (seat belt laws, helmet laws, and speeding limits). Clearly, health departments are not responsible for the enforcement of many or most of these laws. The adoption and implementation of such laws, however, have enormous public health implications. It is important for the health department to be involved in their adoption, monitoring their enforcement, providing follow-up services and/or education, and educating the policy makers and the public about their importance and impact.

Domain 6: Enforce Public Health Laws

DOMAIN 6 INCLUDES THREE STANDARDS:

Standard 6.1:	Review Existing Laws and Work with Governing Entities and Elected/Appointed Officials to Update as Needed
Standard 6.2:	Educate Individuals and Organizations on the Meaning, Purpose, and Benefit of Public Health Laws and How to Comply
Standard 6.3:	Conduct and Monitor Public Health Enforcement Activities and Coordinate Notification of Violations among Appropriate Agencies

STANDARD 6.1: Review existing laws and work with governing entities and elected/appointed officials to update as needed.

Public health laws should be current with public health knowledge, practices, and emerging issues in public health. Laws may need to be revised to also be current with societal actions and behaviors that place individuals or groups at health risk. Health departments must have the legal capacity to review laws, as well as the ability to assess them for recommended changes. Health departments should collaborate and work with the appropriate entities to effect changes to a law, when needed.

Standard 6.1: Review existing laws and work with governing entities and elected/appointed officials to update as needed.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.1.1 A Laws reviewed in order to determine the need for revisions	The purpose of this measure is to assess the health department's analysis of public health laws and other laws that have public health implications to ensure that they are consistent with evidence-based public health and newly emerging public health issues and information. The assessment of laws should consider individual or community cost, inconvenience, impact on systemic health inequities, and regulatory alternatives and sanctions, in addition to the public health program benefits of the law.	Health departments need to be aware of current public health laws and of laws that are not specific to public health but have public health implications, for example, zoning, recreation related, animal related, or transportation laws. These types of laws can have significant impact on health equity. The laws that the health department reviews need not be only laws that the health department enforces. They may also be laws that others enforce but that impact public health, for example, helmet use laws, school nutrition requirements, sale of tobacco products to minors, animal rabies vaccination laws, or school requirements for proof of childhood vaccinations. Program staff of the health department reviews these laws to ensure that they are consistent with evidence-based public health practices and emerging public health issues.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Reviews of public health laws or laws with public health implications that include the following:	**1. The health department must document its evaluation of laws for their public health implications.** Reviews may be of a law that the health department enforces or of a law that the health department has no legal authority to enforce, but that has implications for the health of the public in the jurisdiction of the health department. The documentation may address the review of enforcement protocols and/or adherence to protocols and not of a law itself. This is a program review and does not require the review by a lawyer. Documentation could be, for example, meeting minutes, reports, presentations, memos, or some other record of the discussion of the review and findings. They could also be in the form of policy agendas, position papers, white papers, and legislative briefs, including recommendations for amendments. Health departments must document that the review of the law included:	**2 examples that are from different programs** 1 example must demonstrate collaboration with other levels of health departments (Tribal, state, and/or local)	**Reviews completed within 3 years**

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a. Evaluations of laws for consistency with public health evidence-based and/or promising practices; and consideration of the impact on health equity	a. Consideration of evidence-based practices, promising practices, or practice-based evidence. The impact of the law on health equity in the health department's jurisdiction, if any, must also be considered.		
b. Use of model public health laws, checklists, templates, and/or exercises in reviewing law	b. The use of model public laws, check lists, templates, or some other standard outline or guide. The standard outline or guide could be developed by the health department or by others. Due to the limited availability of evidenced-based practices or promising practices in Tribal communities, Tribes may provide examples of practice-based evidence used to adapt models or create models based on a cultural framework or traditional forms of governance.		
c. Input solicited from key stakeholders on proposed and/or reviewed laws	c. Input from key partners and stakeholders. Input may be sought through, for example, public notice, town forums, meetings, hearings, or request for input on the health department's web page.		
d. Collaboration with other levels of health departments when the laws impact on them	d. Collaboration with other levels of government health departments. State health departments must document that it has collaborated with Tribal or local health departments in reviewing laws that may impact those Tribal or local health departments. This collaboration may involve state health departments providing assistance to Tribal or local health departments as they review and revise laws or it may involve obtaining Tribal or local input on new state laws or revisions of state laws. Specifically, states must consult with Tribal governments on laws that may impact them or for which they are requesting assistance for implementing within Tribal jurisdictions. Documentation of state collaboration could be minutes or summaries of meetings held by the state with Tribal and/or local public health officials; agenda, minutes, and any resulting documents from meetings with stakeholders; summaries of comments from town meetings, hearings, or comments received through a website.		

	Local health departments must document how they consult with Tribes when reviewing laws that impact multiple jurisdictions, for example, disease reporting, isolation and quarantine, and immunizations. Tribal health departments must document work with its local Tribal units (i.e. Chapter Houses, Pueblos, or Districts), in addition to other partners, when reviewing existing laws and revising or creating new laws. Documentation could be, for example, reports of working with local Tribal community stakeholders, for example, elected Tribal District Chairpersons, elected Tribal council committees, Tribal Community Colleges, school districts, and boards. Tribal health documentation may also include work completed with Tribal Legislative Counsel or Tribal Elected/Appointed officials, for example, District Chairpersons, Tribal Oversight Committees, and governing entities.		
2. Access to legal counsel	**2. The health department must document that it has access to legal counsel review and advice for use, as needed.** Documentation could be, for example, an MOU, a contract, a letter of agreement, or statement that a governmental attorney's office has the responsibility to provide legal counsel to the health department.	**1 example**	**3 years**

Standard 6.1: Review existing laws and work with governing entities and elected/appointed officials to update as needed.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.1.2 A Information provided to the governing entity and/or elected/appointed officials concerning needed updates/amendments to current laws and/or proposed new laws	The purpose of this measure is to assess the health department's efforts to provide advice to governing entities and/or elected/appointed officials on the public health impact of the content of new laws and changes to current laws.	The health department can be an expert on the impact of new laws or changes to laws that impact the public's health. As the public health expert for the jurisdiction, the health department should share its findings and make recommendations for amendments – revision, creation, deletion – to the body of public health law. The laws need not be laws that the health department enforces but may be laws that others enforce that impact public health, for example, helmet use laws, school nutrition requirements, sale of tobacco products to minors, texting while driving law, animal rabies vaccination laws, or public school requirements for proof of childhood vaccinations. Not all legal reviews or policy recommendations will result in a change, but health departments have a responsibility to provide the information for consideration by elected/appointed officials.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of written recommendations to governing entity and/or elected/appointed officials concerning amendments or updates to current laws and/or proposed new laws	**1. The health department must document that it has submitted written reviews of current laws or proposals for new laws to the governing entity and/or elected/appointed officials.** Documentation could be, for example, a governing entity meeting agenda, email, or mailed cover memo to governing entity members and elected/appointed officials. For this measure, a public posting, such as a notice on the health department website, would not be sufficient. The documentation must show distribution to the targeted audiences of governing entities and/or elected/appointed officials. Documentation for Tribal health departments could be, for example, work completed with Tribal Legislative Council or Tribal Elected/Appointed officials, for example, District Chairpersons, Tribal Oversight Committees, and other governing entities.	**2 examples** The examples can be, but do not have to be, related to the two examples provided for measure 6.1.1.	**5 years**

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STANDARD 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

Public health laws impact all members of the community. Health departments have the responsibility to educate the public about public health laws and to inform members of the community about the meaning behind the law, the purpose for the law, the benefits of the law, and compliance requirements. Educational efforts should be aimed at individuals and organizations that are a part of the jurisdiction served, including schools, civic organizations, human service organizations, other government units and agencies, and the medical community. Education efforts need to be culturally and linguistically appropriate to the audience.

Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.2.1 A Department knowledge maintained and public health laws applied in a consistent manner	The purpose of this measure is to assess the health department's knowledge of how laws support public health practice and their efforts to ensure that these measures are applied consistently.	Health departments with the responsibility to enforce laws must maintain assurance that the laws are clearly understood by health department staff and that the laws are being applied in a consistent manner. Health departments that do not have regulatory enforcement responsibility still have a responsibility to maintain knowledge of laws that impact public health and to ensure that the laws are applied consistently. For example, the school system may have the responsibility to ensure that all children entering kindergarten have had age appropriate vaccinations. The health department should work with the schools to ensure that those laws are consistently enforced. Another example is the assurance that the prohibition against the sale of tobacco products to minors is enforced consistently.

NOTE: Public health law enforcement, for example, environmental public health, animal control, solid waste and food codes, may be handled by multiple departments within the Tribal, state, or local government. For this measure, the health department must provide documentation of how it maintains knowledge of the laws and their consistent application.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Provisions of training for staff in laws to support public health interventions and practice	**1. The health department must document that the staff are trained in laws that support public health interventions and practice.** The training agenda is not specified and can include both general and specific aspects of public health law. Staff must be trained on the specific aspects of the law for which they are programmatically responsible. For example, an infectious disease nurse should be trained on the law that addresses infectious disease reporting; he or she would not be required to know specific elements on public water laws. Documentation could be, for example, training agendas, minutes of training meetings, HR lists of personnel trained and the date of the training, or screenshots of links to online training required for staff completion and documentation that it was completed. Orientation for new staff is not sufficient.	**2 examples**	**2 years**

2. Efforts to ensure the consistent application of public health laws	**2. The health department must document efforts to ensure the consistent application of public health laws.** Documentation may be a review of either health department staff's application of laws or other organizations' application of public health laws for which the health department is not responsible for enforcement. Coordination with other organizations that apply laws must be evidenced. Examples include enforcement of seat belt use, environmental public health laws, sale of tobacco products to minors, clean indoor air laws, quarantine laws, food safety, etc. Documentation could be, for example, internal audits, enforcement documents or logs, written review of case reports, reports or minutes of meetings with other agencies or entities that enforce laws, communications with other agencies or entities on the importance of consistent application of laws.	**2 examples**	**5 years**

Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.2.2 A Laws and permit/ license application requirements are accessible to the public	The purpose of this measure is to assess the health department's provision of information to the public concerning public health related permits and license applications.	Members of the public will seek information from the health department about laws, permits and license requirements and applications. In some cases, the health department may not be responsible for the administration of the requirements of the laws, but it should be sufficiently informed to correctly advise the public and direct them to the responsible agency.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Public access to information about laws and permit/ license application processes	**1. The health department must document how it makes information concerning public health related laws and permits/license applications available to members of the public who request it.** This information can be made available through the health department's website or provided to the public in a paper document (e.g., flyer, brochure, etc.). The website can post laws, or provide a link to the laws, along with forms, protocols or other components of the permit or licensing process. Information will direct the public to the appropriate agency, if the responsibility does not legally reside with the health department.	**1 example**	**5 years**

Standard 6.2: Educate individuals and organizations on the meaning, purpose, and benefit of public health laws and how to comply.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.2.3 A Information or education provided to regulated entities regarding their responsibilities and methods to achieve full compliance with public health related laws	The purpose of this measure is to assess the health department's education of entities that are responsible for complying with laws that have public health impact. Enforcement of compliance with these laws may or may not be the responsibility of the health department.	A primary role of health departments is to educate the population and regulated entities and organizations about the meaning, purpose, benefits, and compliance requirements of public health related laws.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Provision of information or education to regulated entities concerning their responsibilities for compliance with public health laws	**1. The health department must provide a written record of the provision of information to regulated individuals or entities about their responsibilities related to public health laws.** Documentation must include both the information provided and evidence of its distribution. The information could be provided to a targeted group, such as public schools that are responsible for, for example, enforcing immunization requirements of their students, tracking immunization records, and reporting the vaccination records or lack of records; or, it may be the entire population, who are a regulated entity in regard to the immunization law and their responsibility for having their children vaccinated. Documentation could be, for example, a set of FAQs on the health department's website, newsletters (with distribution list), training sessions (with attendance list and materials), public meetings (with minutes or agendas and attendance list), documentation of technical assistance and information (provided through email, phone logs, etc.), pamphlets, posters, or press releases.	**1 written record**	**5 years**

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STANDARD 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

Health departments have a role in ensuring that public health laws are enforced. In some cases, the health department has the enforcement authority. In other cases, the health department works with those who have the legal authority to enforce the laws. When other state agencies, local departments, or levels of government have enforcement authority, the role of the health department is to collaborate, assist, and share information. In either case, the health department needs to know about enforcement activities and violations in their jurisdiction, since violations and enforcement can impact the public's health. The department should be coordinating and sharing information with agencies that have public health related enforcement authority. The health department is responsible for follow-up communication and education on public health impacts and protection.

As with all of the standards and measures, accountability for meeting the measures rests with the health department being reviewed for accreditation. Documentation that provides evidence of meeting the measure must be provided, even if the documentation is produced by a partner organization, another governmental agency, or another level of government, and not by the health department seeking accreditation. The health department must partner with enforcement agencies to ensure that the laws and their enforcement protect and promote the public's health.

Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.3.1 A Written procedures and protocols for conducting enforcement actions	The purpose of this measure is to assess the health department's standard and consistent enforcement actions.	Enforcement actions require standard steps, criteria, and actions. When public health enforcement is conducted by other agencies or entities, the health department should have working relationships with those entities to share information. The health department may be able to provide advice concerning enforcement. Additionally, the health department should be informed of noncompliance. For example, if a toxic substance is being emitted by a plant or a restaurant inspection identifies a risk of a food borne illness, the health department should be involved to provide public health follow-up on any related illnesses or to deliver community information and education.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Authority to conduct enforcement activities	**1. The health department must document its authority to conduct enforcement activities.** This authority may be located in a state or local code, MOU, letter of agreement, contract, legislative action, executive order, ordinance, or rules/regulations. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department must be coordinating and sharing information with agencies that do have public health related enforcement authority. In those cases, the health department must provide documentation of the authority of the other entity that conducts enforcement.	**2 examples**	**no date restriction**
2. Procedures and protocols for achieving compliance with laws or enforcement actions	**2. The health department must provide copies of procedures, protocols or processes (for example, decision trees) for enforcement program areas.** Where the health department does not conduct public health enforcement actions, the protocols used by the enforcement agency must be provided and must demonstrate cooperation between the enforcement agency and the health department.	**2 examples;** one of the examples must address infectious disease.	**2 years**

Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.3.2 A Inspection activities of regulated entities conducted and monitored according to mandated frequency and/or a risk analysis method that guides the frequency and scheduling of inspections of regulated entities	The purpose of this measure is to assess the health department's adherence to guidelines on the frequency of inspection activities. Where the inspections are conducted by other agencies, the health department should be notified of inspections, protocols, and status. This enables the health department to provide follow-up education and communication, where appropriate, to safeguard the public's health. .	When the law specifies inspection frequency, the health department should be following the defined schedule. When there is no mandated schedule, the health department should have a method to define an appropriate schedule and should adhere to the schedule.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Protocol/algorithm for scheduling inspections of regulated entities	**1. The health department must provide schedules for inspections. The health department may select the areas or programs.** The selected schedules must be in programs where the health department has authority to conduct an inspection of the regulated entity, unless the health department has no such authority. In some cases, schedules for inspections are mandated. In other cases, the department may provide a protocol or an algorithm for scheduling inspections. For example, rules requiring restaurant 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 that has enforcement responsibilities.	**2 examples from 2 different programs**	**5 years**

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2. Inspections that meet defined frequencies with reports of actions, status, follow-up, re-inspections, and final disposition	**2. The health department must document a database or provide a log of inspection reports with actions taken, current status, follow-up, return inspections and final disposition.** Documentation could be screen shots, if the data are kept electronically. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department must coordinate and share information with agencies that do have public health related enforcement authority. In those cases the health department must provide documentation of the authority of the other entity that conducts enforcement. The health department must provide documentation that it is informed of inspection protocols and reports showing the results of inspection.	**2 examples** This documentation of inspections must relate to the same programs for which schedules were provided in 1 above.	**5 years**

Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.3.3 A Procedures and protocols followed for both routine and emergency situations requiring enforcement activities and complaint follow-up	The purpose of this measure is to assess the health department's implementation of procedures and protocols for routine and emergency enforcement activities and for follow up of complaints.	Scheduled investigations, emergency situations, and complaint follow-up should be conducted according to standard procedures and protocols to ensure that they are conducted appropriately.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Actions taken in response to complaints	**1. The health department must document actions taken as a result of investigations or follow-up of complaints, as well as analysis of the situation and standards for follow-up.** Documentation could be, for example, a database or log with analysis and standards for follow-up at each level. The standards for follow-up may be within the procedure and protocols. If separate, the standards must be included with the database or log for the documentation.	**2 examples from 2 different programs**	**5 years**
2. Communications with regulated entities regarding a complaint and compliance plan	**2. The health department must document hearings, meetings, or other official communications with regulated entities regarding a complaint and any resulting compliance plans.** The compliance plan has no specific format and will be determined by law or department protocol. The regulated entity, based on the law, could be an organization, business, or individual. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department must coordinate and share information with agencies that do have public health related enforcement authority. In those cases, the health department must provide documentation of the authority of the other entity to conduct enforcement. The health department must provide documentation that it is informed of inspection protocols and reports showing the results of inspection.	**2 examples**	**5 years**

Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.3.4 A Patterns or trends identified in compliance from enforcement activities and complaints	The purpose of this measure is to assess the health department's analysis of patterns, trends, and compliance from enforcement activities and complaint investigations.	It is important for the health department to determine patterns or trends in non- compliance, complaints, or enforcement activities. This will help in understanding the prevalence of issues, in employing preventive measures, in pursuing opportunities for improvement in enforcement activities, and in providing follow-up education.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Enforcement programs' annual reports summarizing complaints, enforcement activities, and compliance	**1. The health department must provide annual reports that summarize complaints, enforcement activities, or compliance. Reports must include patterns, trends, and compliance.** Documentation from an enforcement program that is out of compliance with state law or is under sanctions or a performance improvement plan must be labeled as being out of compliance with state law or under sanctions or a performance improvement plan.	**2 examples from different enforcement programs.** If the department operates an enforcement program that is out of compliance with state law or is under sanctions or a performance improvement plan, then one of the examples must be from that program.	**14 months**

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2. Debriefings or other evaluations on enforcement for process improvements	**2. The health department must document debriefings or other methods to evaluate what worked well, problems that arose, issues and recommended changes in investigation/response procedures, and other process improvements to enforcement protocols or procedures.** All other process improvements discussed must be noted in the documentation. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department must coordinate and share information with agencies that do have public health related enforcement authority. In those cases, the health department must provide documentation of the authority of the other entity to conduct enforcement. The health department must document that it is informed of patterns, trends, and compliance.	**2 examples**	**5 years**

Standard 6.3: Conduct and monitor public health enforcement activities and coordinate notification of violations among appropriate agencies.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 6.3.5 A Coordinated notification of violations to the public, when required, and coordinated sharing of information among appropriate agencies about enforcement activities, follow-up activities, and trends or patterns	The purpose of this measure is to assess the health department's communication with the public concerning enforcement violations and with appropriate agencies concerning enforcement activities, follow-up activities, and trends or patterns. In some cases, the health department may have little or no authority to conduct enforcement actions. In those cases, the department should be coordinating and sharing information with agencies that do have public health related enforcement authority.	It is important that the health department share enforcement information with the public so that the public may make decisions or alter their behavior, based on the information. For example, many members of the public want to know what local restaurants have failed inspection and why. It is important that the health department shares information concerning enforcement actions and/or any resulting follow-up with other agencies that have a role in educating or providing follow-up with the enforced entity or educating the public. Appropriate agencies include health departments at other levels of government: Tribal, state, or local health departments.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Communication protocol for interagency notifications	**1. The health department must provide a communication protocol for interagency notifications.** The protocol may be in parts to address multiple communication protocols or it may be a single comprehensive protocol for notifying other agencies concerning enforcement actions.	**1 protocol**	**5 years**
2. Protocol for notification of the public of enforcement activities	**2. The health department must provide a protocol for notifying the public of enforcement activities.** If there are laws that require public notification, the reference must be submitted. The health department may also allow for public notification without a legal requirement. In that case, provide a copy of the relevant protocol. Examples include notifications of the public of restaurant inspection violations, emission violations, and inspections of public facilities (for example, public swimming pools).	**1 department-wide protocol or 2 examples**	**5 years**

3. Notifications of enforcement actions and other sharing of information concerning enforcement activities	**3. The health department must document the notification of enforcement actions.** Required Documentation 1 and 2 requires written protocols. Required Documentation 3 requires documentation of the implementation of a protocol. Documentation must demonstrate that protocols were followed. Notification can be through a variety of methods, including: posting on a website, minutes from public meetings, conference calls, emails, correspondence, press release, public presentation, reports, and MOUs and MOAs with other agencies that demonstrate sharing information on enforcement activities. When other agencies have enforcement authority, the health department must provide documentation that it is informed of patterns, trends, and compliance.	**2 examples are required.** The two examples must be from two different enforcement programs.	**5 years**

Domain 7: Promote Strategies to Improve Access to Health Care

Domain 7 focuses on the population's access to needed health care services. An important role of public health is the assessment of the population's access to health care services and the capacity of the health care system to meet the health care needs of the population. Public health also has a role in efforts to increase access to needed health care services, particularly primary care. The focus of this Domain is not on health care or clinical services that the health department may provide directly, though those services are part of the analysis of access to health care.

DOMAIN 7 INCLUDES TWO STANDARDS:

Standard 7.1:	Assess Health Care Service Capacity and Access to Health Care Services
Standard 7.2:	Identify and Implement Strategies to Improve Access to Health Care Services

STANDARD 7.1: Assess health care service capacity and access to health care services.

Health departments should work with the health care system to (1) understand the availability of health care services to the population, (2) identify populations who experience barriers to health care services, and (3) identify gaps in access to health care and barriers to the receipt of care.

Standard 7.1: Assess health care service capacity and access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.1.1 A Process to assess the availability of health care services	The purpose of this measure is to assess the health department's participation in a collaborative process to develop an understanding of the population's access to needed health care services.	Collaborative efforts are required to assess the health care needs of the population of the Tribe, state, or community. The focus is on the need for primary care, particularly preventive primary care and chronic disease management. Health care services, for access planning purposes, include: clinical preventive services, emergency services, urgent care, occupational medicine, ambulatory care (primary and specialty), and dental treatment.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A collaborative process to assess availability of health care services	**1. The health department must document its participation in a collaborative process to assess the availability of health care services to the population.** The collaborative process must include the involvement of the health care system. Other partners may include, for example, representatives of social service organizations, employers, health insurance companies, communities of color, Tribes, low income workers, military installations, correctional agencies, specific populations who may lack health care and/or experience barriers to service (e.g., disabled, non-English speaking, or otherwise disenfranchised residents), and other stakeholders. For Tribal health departments it may include clinic and hospital representatives, Indian Health Service, other Tribal programs and departments, and individuals representing communities that experience barriers to services (e.g., distance from service, transportation barriers). Information on the partnerships developed to assess health care must include rosters of coalition/network/council members. Documentation could be, for example, charters or meeting agendas, or meeting minutes.	**1 collaborative process**	**5 years**

2. The sharing of comprehensive data for the purposes of assessing the availability of health care services and for planning	**2. The health department must document the sharing of public health Tribal, state, and/or local data for assessment and planning purposes.** Sharing mechanisms can include regional health information organizations (RHIOs) and health information exchanges (HIEs), or less formal data sharing efforts, for example, MOUs or contracts. Documentation could be examples of data sharing through reports, emails, etc.	**2 examples**	**5 years**
3. Consideration of emerging issues in public health, the health care system, and health care reimbursement	**3. The health department must document consideration of emerging issues that may impact access to care.** These might include changes in the structure of the health care system; types and numbers of health care professionals being trained; changes in reimbursement structure, rates, or payment mechanisms such as accountable care organizations; developing care models, for example, coordinated care organizations or convenient care clinics; and electronic medical records. Documentation could be, for example, meeting minutes, reports, or white papers.	**2 examples**	**5 years**

Standard 7.1: Assess health care service capacity and access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.1.2 A Identification of populations who experience barriers to health care services identified	The purpose of this measure is to assess the department's knowledge of barriers to health care and of the specific populations who experience those barriers.	It is important for the health department to identify populations in its jurisdiction that experience perceived or real barriers to health care. Assessing capacity and access to health care includes the identification of those who are not receiving services and understanding the reasons that they are not receiving needed care or experiencing barriers to care. Barriers may be experienced, for example by populations who are uninsured or under-insured, have no transportation to health care, are non-English speaking, are immuno-compromised, or live where there is a shortage of primary care practitioners. Barriers may also be perceived by populations who do not trust the health care system or do not understand why certain routine medical services or screenings are necessary for their health. The importance of access to health care services includes, for example: pregnant women who use tobacco (who are at risk of giving birth to a low birth weight baby); obese populations (who are at risk for diabetes); or individuals who use tobacco products (who are at risk for cancer).

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A process for the identification of un-served or under-served populations	**1. The health department must document the process and information used to identify populations who lack access to health care.** Information could be obtained from an assessment survey and/or surveys of particular population groups. Other information sources include: analysis of secondary data and/or health care data, such as emergency department admissions or population insurance status data.	**1 process**	**5 years**
2. A report that identifies populations who are un-served or under-served	**2. The health department must provide a report that identifies populations who experience barriers to health care services.** Populations may be identified by a variety of characteristics, for example, age (e.g., teenagers, elderly, etc.), ethnicity, geographic location, health insurance status, educational level obtained, mental or physical disabilities, discrimination (e.g., marriage inequality), or special health service needs (women who are pregnant, individuals with diabetes, etc.). This report could be a section of a larger report that includes other topic, a separate report, or part of the community health improvement plan.	**1 report**	**5 years**

Standard 7.1: Assess health care service capacity and access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.1.3 A Identification of gaps in access to health care services and barriers to the receipt of health care services identified	The purpose of this measure is to assess the health department's knowledge of gaps in access and barriers to health care services among the population it serves.	It is important for health departments to understand the gaps in access to health care and the barriers to care so that effective strategies can be put in place to address the lack of access to health care. Barriers to health care services can range from financial (e.g., lack of affordable services), health care system capacity (e.g., lack of dental providers), cultural (e.g., lack of interpreters), geographic (e.g., lack of transportation), and lack of health insurance, among others. Shared data among the members of the partnership can evidence an effort to capture and understand all possible gaps that exist.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The process or set of processes used for the identification of service gaps and barriers to accessing health care services	**1. The health department must document the process used to identify gaps in health care services and barriers to care.** The documentation must identify who was involved in the identification process. Processes may include sector maps, analysis of hospital admissions or emergency department data, analysis of health insurance data, or other tools.	**1 process or set processes**	**5 years**
2. Reporting the analysis of data from across the partnership (see 7.1.1) that identify the gaps in access to health care services and the causes of gaps in access, or barriers to care. **Reports must include:**	**2. The health department must provide reports of analysis of data from various partnership sources that identify and describe gaps in access and barriers to health care services.** Reports must include analysis of data and conclusions that can help develop effective strategies to address gaps in access. At a minimum, data sources must include the partners that participated in the collaborative process described in measure 7.1.1. Data may be contributed by all partners or may be discussed or evaluated by partners. The reports must include:	**2 examples**	**5 years**

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a. Assessment of capacity and distribution of health care providers	a. Assessment of capacity and distribution of health care providers. These data will show geographic gaps in the availability of health care providers.		
b. Availability of health care services	b. Assessment of the availability of health care services, for example, clinical preventive services, EMS, emergency departments, urgent care, occupational medicine, ambulatory care (primary and specialty), inpatient care, chronic disease care (e.g., diabetic care, HIV health services), dental, and other health care services. These data can be useful in seeking support for a particular service.		
c. Identification of causes of gaps in services and barriers to receipt of care	c. Assessment of cause(s) for lack of access to services and barriers to access to care. Causes may include: a population that is uninsured/under-insured, lacks transportation to health care, does not speak or understand English, is immuno-compromised, or lives where there is a shortage of primary care and dental practitioners. Barriers may also be the result of populations who do not trust health care providers or do not understand why certain routine medical services or screenings are necessary to protect their health. Barriers may include, but not be limited to, travel distance in rural areas, inability to obtain timely appointments, lack of ability to pay for services, or limited service hours of health care.		
d. Results of data gathered periodically concerning access	d. Results of data or information gathered concerning access, for example, focus groups, studies of eligible groups receiving services, and other assessment information, can provide perspectives from the population that lacks access. These data collection efforts do not have to be administered by the health department, but the results must be considered in the assessment of gaps in access and barriers to care.		

STANDARD 7.2: Identify and implement strategies to improve access to health care services.

There are many factors that can contribute to lack of access to health care, including insurance status, transportation, travel distance, availability of a regular source of care, wait time for appointments, and office wait times. Social conditions also influence access to health care, including education and literacy level, language barriers, knowledge of the importance of symptoms, trust in the health care system, and employment leave flexibility. Once the barriers and gaps in service are identified, strategies may be developed and implemented to address them and improve access to health care services.

Standard 7.2: Identify and implement strategies to improve access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.2.1 A Process to develop strategies to improve access to health care services	The purpose of this measure is to assess the health department's collaborative efforts to develop strategies to increase access to health care for those who experience barriers to services.	Factors that contribute to poor access to care are varied. A partnership with other organizations and agencies provides the opportunity to address multiple factors and coordinate strategies. The health department need not have convened or have led the collaborative process, but it must have participated in the process.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A coalition/ network/ council working collaboratively to reduce barriers to health care access or gaps in access	**1. The health department must document its involvement in a collaborative process for developing strategies to improve access to health care.** The example must demonstrate involvement of representatives of providers of health care services, for example, hospitals, clinics, primary care physicians, etc. Other partners may include, for example: community service providers, schools, correctional agencies, migrant health, social service organizations, transportation providers, military installations, and employers. The documentation must demonstrate that the group is actively working to identify strategies. The collaborative process and development of strategies in this measure can be done in conjunction with 7.1.1, and the same collaborative process/partnership can be used. Documentation could be, for example, a charter for the group; membership rosters or participant/attendance lists; meeting agendas and minutes; or workgroup reports, work plans, and white papers.	**1 collaborative process**	**5 years**

2. Strategies developed by the coalition/ network/council working through a collaborative process to improve access to health care services	**2. The health department must provide strategies that the coalition/ network/council developed to improve access to health care services and reduce barriers to care.** Examples include: linking individuals with needed and convenient services; establishing systems of care in partnership with other members of the community; addressing transportation barriers; addressing cuts in budgets and clinic hours; expanding roles of care givers (e.g., mid-level providers) to provide screenings and referrals; working with employers to increase the number of insured workers; or other strategies to address particular barriers. Documentation could be, for example, reports, meeting minutes, or MOUs.	**2 examples**	**5 years**

Standard 7.2: Identify and implement strategies to improve access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.2.2 A Implemented strategies to increase access to health care services	The purpose of this measure is to assess the health department's involvement in the implementation of strategies to increase access to health care services.	Improved access to care will provide continuity of health promotion and disease prevention to members of the population and ensure access to needed preventive services.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Collaborative implementation of mechanisms or strategies to assist the population in obtaining health care services	**1. The health department must document collaborative implementation of strategies to improve access to services for those who experience barriers.** Documentation could be, for example: • A signed Memoranda of Understanding (MOU) between partners to list activities, responsibilities, scope of work, and timelines. • A documented cooperative system of referral between partners that shows the methods used to link individuals with needed health care services. • Documentation of outreach activities, case findings, case management, and activities to ensure that people can obtain the services they need. • Documentation of assistance to eligible beneficiaries with application and enrollment in Medicaid, workers' compensation, or other medical assistance programs. • Documentation of coordination of service programs (e.g., common intake form) and/or co-location (e.g., WIC, immunizations, and lead testing) to optimize access. • Grant applications submitted by community partnerships that address increased access to health care services. • Subcontracts in the community to deliver health care services in convenient and accessible locations. • Program/work plans documenting that strategies developed collaboratively have been implemented. • Documentation of transportation programs.	**2 examples**	**5 years**

Standard 7.2: Identify and implement strategies to improve access to health care services.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 7.2.3 A Implemented culturally competent initiatives to increase access to health care services for those who may experience barriers to care due to cultural, language, or literacy differences	The purpose of this measure is to assess the health department's involvement in the incorporation of cultural competence, language, or literacy in efforts to address the health care service needs of populations who experience barriers to access to health care.	Cultural differences can present serious barriers to receipt of health care services. Cultural differences must be addressed in strategies to improve access to health care services, if those strategies are to be successful. For example, some cultures discourage women from talking about personal issues with people outside of their families, discourage men from seeking care, may not trust health care providers, or may rely on community providers who are not trained in medical care. Language and low literacy can also limit access to care.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Initiatives to ensure that access and barriers are addressed in a culturally competent manner	**1. The health department must document that initiatives to ensure access and address barriers are culturally competent, and take into account cultural, language, or low literacy barriers.** The initiatives may be developed by the health department or in collaboration with others. Examples of initiatives include the use of lay health advocates indigenous to the target population; parish nursing; informational materials developed for low literacy individuals; culturally competent initiatives developed with members of the target population; language/interpretive services; family-based care for some populations; or provision of health care that combines cultural health care and the health care system.	**2 examples**	**5 years**

Domain 8: Maintain a Competent Public Health Workforce

Domain 8 focuses on the need for health departments to strategically approach the development of a competent workforce to perform public health duties. Effective public health practice requires a well prepared workforce. A multi-disciplinary workforce that is matched to the specific community being served facilitates the interdisciplinary approaches required to address health equity and the population's public health issues. The manner in which services are provided to the public determines the effectiveness of those services and influences the population's understanding of, and appreciation for, public health. A strategic workforce includes the alignment of workforce development with the health department's overall mission and goals and the development of strategies for acquiring, developing, and retaining staff.

DOMAIN 8 INCLUDES TWO STANDARDS:

Standard 8.1:	Encourage the Development of a Sufficient Number of Qualified Public Health Workers
Standard 8.2:	Ensure a Competent Workforce through Assessment of Staff Competencies, the Provision of Individual Training and Professional Development, and the Provision of a Supportive Work Environment

STANDARD 8.1: Encourage the development of a sufficient number of qualified public health workers.

Maintaining a competent public health workforce requires a supply of qualified public health workers sufficient to meet public health needs. As public health workers retire or seek other employment opportunities, newly trained public health workers must enter the field. Trained and competent workers are needed in such diverse areas as epidemiology, health education, community health, public health laboratory science, public health nursing, environmental public health, and public health administration and management. Every health department has a responsibility to collaborate with others to encourage the development of a sufficient number of public health students and to encourage qualified individuals to enter the field of public health to meet the staffing needs of public health departments and other public health related organizations.

Standard 8.1: Encourage the development of a sufficient number of qualified public health workers.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.1.1 S Relationship and collaboration with educational programs that promote the development of future public health workers	The purpose of this measure is to assess the state health department's contributions to the development of qualified public health workers.	Working with schools of public health and other related academic and educational programs (for example, public health nursing, public health laboratory services, health promotion, environmental public health, public policy, colleges of veterinary medicine) is a means to promote public health as an attractive career choice. Collaborative efforts promote the health department as an employer of choice and open new pathways for recruitment. Collaboration with academic programs can create opportunities for internships, guest lecturers, and other ways to expose students or new graduates to public health practice.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Partnership or ongoing collaboration with educational programs to promote public health as a career or to provide training in public health fields	**1. The state health department must document a partnership or collaboration with a school of public health and/or other related academic programs that prepare public health workers.** The documentation must show strategies for promoting public health careers or enhancing training in public health. Examples of partnership or collaboration include: a practicum; student placements/academic service learning; internship opportunities; faculty positions or guest lectures by health department staff; participation in high school, university, college, or Tribal college programs; and/or job/career fairs.	**1 partnership or ongoing collaboration**	**5 years**

Standard 8.1: Encourage the development of a sufficient number of qualified public health workers.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.1.1 T/L Relationships and/or collaborations that promote the development of future public health workers	The purpose of this measure is to assess the health department's activities to encourage public health as a career choice.	Working with schools, academic programs, or other organizations is a means to promote public health as an attractive career choice. Collaborations can create paths for exposing students or new graduates to public health practice.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Relationship or collaboration that promotes public health as a career	**1. The health department must document a partnership or collaboration that promotes public health as a career choice.** Examples of partnerships or collaborations include collaboration with a school or college of public health, working with organizations such as AmeriCorps, coordinating with a high school to make presentations to students about public health and public careers, working with a vocational training school to promote public health, partnering with a 4H club to provide information about public health to members, guest lecturing at a community college, or providing after school experiences for high school students.	**1 example**	**5 years**

STANDARD 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

A health department workforce development plan ensures that staff development is addressed, coordinated, and appropriate for the health department's needs. Staff job duties and performance should be regularly reviewed to note accomplishments and areas that need improvement. This should not be a punitive process but one that identifies needs for employee training or education. This approach can point out gaps in competencies and skills for the health department and provide workforce development guidance for individual staff members.

Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.2.1 A Workforce development strategies	The purpose of this measure is to assess the health department's planning for employee training, implementation of those plans, and the development of core competencies.	Health departments must have a competent workforce with the skills and experience needed to perform their duties and carry out the health department's mission. Workforce development strategies support the health department, individual staff members, staff development, and the overall workplace environment. Employee training and core staff competencies assure a competent workforce.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Workforce development plan	**1. The health department must provide a health department-specific workforce development plan.** The workforce development plan must: • Address the collective capacity and capability of the department workforce and its units. • Address gaps in capacity and capabilities and include strategies to address them. • Be responsive to the changing environment and include consideration of areas where the technology advances quickly such as information management and (digital) communication science. • Be responsive to the changing environment and include considerations of areas where the field is advancing, for example, emergency preparedness training, health equity, and cultural competence. The plan must include: • An assessment of current staff competencies against the adopted core competencies. An example of nationally adopted core competencies is the "Core Competencies for Public Health Professionals" from the Council on Linkages Between Academia and Public Health Practice. The plan may also use state developed or specialty focused sets of competencies, for example, nursing, public health preparedness, informatics, and health equity competencies.	**1 plan**	**2 years**

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	• Training schedules and a description of the material or topics to be addressed in the training curricula to address gaps in staff competencies. • A description of barriers/inhibitors to the achievement of closing gaps or addressing future needs in capacity and capabilities and strategies to address those barriers/inhibitors.		
2. Implemented workforce development strategies	**2. The health department must document implementation of its workforce development strategies.** Examples must demonstrate how the health department addresses gaps in capacity and capabilities.	**2 examples**	**2 years**

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Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.2.2 A A competent health department workforce	The purpose of this measure is to assess the health department's execution of its workforce development plan related to recruitment, retention, and staff qualifications.	Health departments' success, as in all organizations, depends on the capabilities and performance of its staff. Actions that maximize staff capabilities and performance are necessary for a health department to function at a high level.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Recruitment of qualified individuals for specific positions	**1. The health department must document the recruitment of individuals who are qualified for their public health specific specialty position.** Examples of the evidence of the efforts of the health department to achieve the desired applicant pool are required. Documentation could be, for example, a competency-based job description and requirement for specific certification posting that specifies the level of skills, training, experience, and education that the applicant needs to possess to qualify for the position.	**2 examples**	**5 years**
2. Recruitment of individuals who reflect the population served	**2. The health department must document the recruitment of individuals who reflect the demographics (e.g., race, ethnicity, language, etc.) of the population that the health department serves.** Examples of the evidence of the efforts of the health department are required, not the success or failure to achieve the desired applicant pool. Tribal health departments may use Indian Preference hiring policies.	**2 examples**	**5 years**
3. Retention activities	**3. The health department must document activities to retain staff.** Examples include: employee satisfaction survey results, needs assessments of work environment, reward and recognition programs, career ladders, promotion opportunities, and supervisor mentoring programs.	**2 examples**	**5 years**

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4. Position descriptions, available to staff	**4. The health department must provide position descriptions or job descriptions.** Position or job descriptions must include the competencies that are required for the position and must address both public health specialty needs (e.g., epidemiologist, public health laboratory technician, etc.) and generalist needs. The health department must also document how the descriptions are made available to staff. They may be made available for example, through the internet/intranet, a policy procedures manual, or through the human resources department.	**2 examples**	**3 years**
5. A process to verify staff qualifications	**5. The health department must document the process used to verify staff qualifications.** This process may be defined in policy or it may be found in personnel guidelines that are part of the human resources system or a central administrative unit, such as a civil service system. Other examples include: guidelines used by all Tribal/county/state agencies or a separate process defined and used by the health department. The process may include: reference checks; confirmation of transcripts with the issuing academic institution; confirmation of any registration, certification, or license with the issuing institution; or other check of credentials provided by the staff member. Tribal health departments may include using the Indian Preference hiring policies and/or proof of enrollment.	**1 process**	**2 years**
6. Verified qualifications for all staff hired	**6. The health department must document that qualifications have been verified for all staff hired in the past two years.** Reviews include tracking required recertification. Documentation could be, for example, personnel files, a log or spreadsheet, or a template or form used by the health department; civil service commission certification; or evidence from a county or state personnel office demonstrating that the person is qualified for the position. Tribes often operate a human resources department to support its administration, including the Tribal health department. If this is the case, the health department must demonstrate how it works with human resources to ensure that it follows the appropriate policies and procedures.	**2 examples**	**2 years**

Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.2.3 A Professional and career development for all staff	The purpose of this measure is to assess the health department's comprehensive approach to the provision of opportunities for professional career development for all staff and the department's implementation of staff development activities.	All staff should have opportunities for professional development. All employees need to have a basic understanding of public health in order to coordinate program efforts, especially in the case of working with the public and in the case of emergency situations. All staff should have opportunities to learn and to grow in their positions both to improve their own skills and also to address the changing needs of the health department. In addition to their specific public health activities, leaders and managers must oversee the health department, interact with stakeholders and constituencies, seek resources, interact with governance, and inspire employees and the community to engage in healthful public health activities. Development activities can assist leadership and management to employ state-of-the-art theory, management processes, public health knowledge, and management techniques.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Participation in personal professional development activities by staff of the department (other than management and leadership staff, who are addressed below)	**1. The health department must document staff's completion of their annual personal professional development plan.** Professional development activities could include: education assistance (e.g., time off for classes, tuition reimbursement, bringing classes to the health department), continuing education, training opportunities, mentoring, job shadowing, certification in public health, etc. Topics could be, for example, HIPAA, emergency response, methods for the presentation of data, health equity, communications, and courses required for Certified Public Health continuing education. Documentation could be, for example, a training completion certificate, an attendance record for a class, or a report written by the staff person documenting the activities and learnings.	**2 examples**	**2 years**

2. Development activities for leadership and management staff	**2. The health department must document the provision of department training and development programs for department leaders and managers.** Activities could include, for example, education assistance, continuing education, support for membership in professional organizations, and training opportunities.	**2 examples**	**2 years**
3. Participation of department leaders and managers in training provided by others, outside of the health department	**3. The health department must document leaders' and/or managers' attendance at a leadership and/or management development training. Online courses are acceptable.** Examples of providers include National Public Health Leadership Institutes; Public Health Training Centers Network, Environmental Public Health Leadership Institute; executive management seminars or programs; graduate programs in leadership/management; and related meetings and conferences. Examples of course topics include negotiation skills, CQI, systems thinking, change management, intercultural or intergenerational management, collaborative intelligence, handling conflict, coaching and mentoring skills, communications skills for managers, leadership styles, effective networks, concepts of public health informatics, leading teams and collaborations, health equity, community resilience, relationship building, marketing/branding, business process improvement, digital media, and crisis/risk communication.	**2 examples**	**2 years**

Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.2.4 A Work environment that is supportive to the workforce	The purpose of this measure is to assess the health department's efforts to create an organizational culture and work environment that is supportive of the staff and their maximum productivity.	A positive work environment is vital to the success of any organization. The work environment impacts job satisfaction, employee retention, and employee creativity and productivity. The work environment should support and foster each employee's ability to contribute to the achievement of the department's mission, goals, and objectives.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Policies that provide an environment in which employees are supported in their jobs	**1. The health department must provide policies that provide a supportive work environment.** Policies could include, for example: • A work/life balance, for example, telecommuting, flex time, and breastfeeding/ lactation support; • Diversity (especially for staffing to match the diversity of the population); • Leadership attributes, for example, setting a professional tone; fair and equitable management decisions; focus on the department's vision and mission; • Regular assessments of the organizational climate, for example, regular staff surveys and 360 reviews of the management team; • The provision of the tools, information, and freedom to allow staff to perform their responsibilities; • The maintenance of institutional memory, the transfer of knowledge, and the celebration of past and current accomplishments, for example, partnerships with retirees, sharing of stories, celebration events, etc. • Supervisors' encouragement of systems thinking, change management, data use for decisions, and a culture of quality improvement; and • Collaborative learning, for example participation of staff on boards, committees, and task forces in community, collaborative planning sessions, shared reviews of program evaluations, etc.	**1 policy or set of policies, plans, or program descriptions**	**5 years**

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2. A process for employee recognition	**2. The health department must provide employee recognition policies. Examples can address both team and individual recognition and recognition for employee improvement.** Examples of employee recognition include a call out in a newsletter, employee of the month program, posting an employee honor roll, recognition letters, regularly organized recognition lunch, etc.	**1 set of policies, plans, or program descriptions**	**5 years**
3. Employee wellness activities	**3. The health department must provide a policy, plan, or description of opportunities provided to staff to promote health and wellness and prevent disease.** Activities may include, for example, health screenings and risk assessments, flu shots, exercise programs, nutrition information, stress reduction methods, breastfeeding and lactation support, and tobacco use cessation. Examples may also include healthy food policies and efforts to create a culture of health and wellness.	**1 policy, plan, or program description**	**5 years**

Standard 8.2: Ensure a competent workforce through the assessment of staff competencies, the provision of individual training and professional development, and the provision of a supportive work environment.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 8.2.5 S Consultation and/or technical assistance provided to Tribal and local health departments regarding evidence-based and/or promising practices in the development of workforce capacity, training, and continuing education	The purpose of this measure is to assess the state health department's provision of consultation and/or technical assistance to Tribal and local health departments on evidence-based and/or promising practices in the development of workforce capacity, workforce training, and/or continuing education.	The state health department has knowledge and experience to share about workforce capacity, workforce training, and continuing education to address organizational gaps in the public health workforce. A trained and competent Tribal or local health department workforce enhances the capacity of the state health department.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The provision of consultation and/or technical assistance to Tribal or local health departments	**1. The state health department must document consultation or technical assistance provided to Tribal or local health departments.** Documentation could include, for example, emails, phone calls, webinars, documents/materials, site-visits, meetings, training sessions, and web postings.	**2 examples** The state health department must include one example of assistance provided to a Tribal health department, and one example of assistance provided to a local health department. If the state does not contain any Tribal health departments, then the two examples must be from local health departments.	**5 years**

Domain 9: Evaluate and Continuously Improve Processes, Programs, and Interventions

Domain 9 focuses on the use and integration of performance management and quality improvement practices and processes for the continuous improvement of the public health department's practices, programs, and interventions.

Performance management identifies actual results against planned or intended results. Performance management systems ensure that progress is being made toward department goals by systematically collecting and analyzing data to track results to identify opportunities and targets for improvement.

Quality improvement is an element of performance management that uses processes to address specific targets for effectiveness and efficiency. "Quality improvement in public health is the use of a deliberate and defined improvement process that is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community." (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. Defining Quality Improvement in ***Public Health. Journal of Public Health Management and Practice***. January/February 2010).

DOMAIN 9 INCLUDES TWO STANDARDS:

Standard 9.1:	Use a Performance Management System to Monitor Achievement of Organizational Objectives
Standard 9.2:	Develop and Implement Quality Improvement Processes Integrated Into Organizational Practice, Programs, Processes, and Interventions

STANDARD 9.1: Use a performance management system to monitor achievement of organizational objectives.

For the health department to most effectively and efficiently improve the health of the population, it is important to monitor the performance of public health processes, programs, interventions, and other activities. A fully functioning performance management system that is completely integrated into health department daily practice at all levels includes: 1) setting organizational objectives across all levels of the department, 2) identifying indicators to measure progress toward achieving objectives on a regular basis,3) identifying responsibility for monitoring progress and reporting, 4) identifying areas where achieving objectives requires focused quality improvement processes, and 5) visible leadership for ongoing performance management. Department information systems and public health data support performance management.

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.1 A Staff at all organizational levels engaged in establishing and/or updating a performance management system	The purpose of this measure is to assess the health department's engagement of leadership and staff in developing, establishing, using, and updating a performance management system for the organization.	To continuously improve public health practice, the health department leadership and staff need to commit to establishing and using a performance management system. The performance management process must intentionally engage all levels of the organization in reaching decisions about the functionality and integration of various components of the performance management system. Staff ownership is required because implementation of a performance management system is successful only when staff is involved early and continuously in decision making. When department leadership and staff work together to promote the use of performance management practices, it is easier to achieve an integrated performance management system. Keeping top-down and bottom-up dialogue alive reinforces the importance of organizational excellence inherent in a fully functioning and completely integrated performance management system.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Health department leadership and management supportive and engaged in establishing and/or updating a performance management system	**1. The health department must document the health department leadership's engagement in setting a policy for and/or establishing a performance management system for the department.** Documentation could be, for example, strategic and operational plans; training agendas, training programs, meeting agendas, packets, materials and minutes; draft policies or items discussed with the governing entity, and/or presentations to the governing entity. Documentation may include minutes of team meetings, quality council monthly reports, and final reports from teams showing results achieved.	**2 examples**	**5 years**
2. Health department staff at all other levels engaged in establishing and/or updating a performance management system	**2. The health department must document engagement of staff at all levels of the department in determining the nature of a performance management system for the department and implementing the system.** Documentation could be, for example, meeting agendas, packets, materials, and minutes; orientation presentations/programs for new personnel; health department meeting materials and operational plans.	**2 examples**	**5 years**

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.2 A Performance management policy/ system	The purpose of this measure is to assess the health department's adoption of a department-wide performance management system.	A performance management system encompasses all aspects of using objectives and measurement to evaluate performance of programs, policies, and processes, and achievement of outcome targets. An adopted performance management system communicates across the department how the department will (1) ensure that goals are being met consistently in an effective and efficient manner and (2) identify the need to improve organizational results.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. An adopted performance management system	**1. The health department must provide a written description of the department's adopted performance management system that includes:** a. Performance standards, including goals, targets and indicators, and the communication of expectations; b. Performance measurement including data systems and collection; c. Progress reporting including analysis of data, communication of analysis results, and a regular reporting cycle; and d. A process to use data analysis and manage change for quality improvement and towards creating a learning organization.	**1 performance management system**	**5 years**

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.3 A Implemented performance management system	The purpose of this measure is to assess the health department's management practices for assessing performance and identifying and managing opportunities for improvement.	A performance management system ensures that progress is being made toward department goals and allows the department to identify areas for quality improvement. Assessing current capability helps identify objectives in a structured way. There are a variety of performance management system models to assess and manage performance and identify opportunities for improvement. Formal, fully functioning, integrated performance management systems are feasible in every health department, yet health departments may be using only some components of a performance management system. Identifying the performance management practices being used will help determine the extent to which components of a performance management system exist and which components need to be developed.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A functioning performance management committee or team	**1. The health department must provide documentation of a department committee, team, council, executive team, or some other entity that is responsible for implementing the performance management system.** This does not have to be a separate group that deals only with performance management but may be a function of a standing department committee. Documentation could be, for example, a charter, agendas, minutes, reports, or protocols of the subsidiary body responsible.	**1 example**	**5 years**

2. Goals and objectives	**2. The health department must document setting of goals and objectives with the identified time frames for measurement.** Examples of administrative areas where performance management might be appropriate include contract management (e.g., looking at the contract approval process or how contracts are tracked for compliance), vital records (e.g., processing birth and death certificates or evaluating their accuracy), human resources functions (e.g., the performance appraisal system), staff professional development (e.g., effectiveness of the professional development process), workforce development (e.g., appropriateness of employee wellness program), or financial management system (e.g., the financial data development, analysis, and communication process). Documentation could be provided in narrative, table, or graphic form, depending on the chosen reporting method.	**2 examples;** one example must be from a programmatic area and the other from an administrative area.	**5 years**
3. Implementation of the process for monitoring the performance of goals and objectives	**3. The health department must document the monitoring of performance towards the two objectives cited above.** Documentation could be, for example, from run charts, dashboards, histograms, data reports, monitoring logs, or other statistical tracking forms demonstrating analysis or progress in achieving measures; or meeting minutes from a quality team.	**2 examples**	**5 years**
4. Analysis of progress toward achieving goals and objectives and identification of areas in need of focused improvement processes	**4. The health department must document that performance of the two objectives identified in 2) above was analyzed according to the time frames.** Evidence for determining opportunities for improvement can be shown through the use of tools and techniques, for example, root cause analysis, cause and effect/Fishbone; or interrelationship digraphs or other analytical tools.	**2 examples**	**5 years**
5. Identification of results and next steps	**5. The health department must document that performance results, opportunities for improvement, and next steps for the identified goals and corresponding objectives were documented and reported.**	**2 examples**	**5 years**

6. A completed performance management self-assessment	**6. The health department must provide a completed performance management self-assessment that reflects the extent to which performance management practices are being used.** The health department may develop its own performance management assessment or use existing models, such as The Public Health Performance Management Self-Assessment Tool (http://www.phf.org) or the Self-assessment tools available through the Baldrige Performance Excellence Program (http://www.nist.gov/baldrige/enter/self.cfm).	**1 self-assessment**	**5 years**

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.4 A Implemented systematic process for assessing customer satisfaction with health department services	The purpose of this measure is to assess the health department's process for measuring the quality of customer relationships and service.	Customer focus is a key part of an organization's performance management system. To evaluate the effectiveness and efficiency of the health department's work, it is essential to identify customers and stakeholders, both internal and external. A health department also needs a process to capture and analyze customer feedback in order to address the expectations of various public health customers.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Collection, analysis, and conclusions of feedback from two different customer groups	**1. Using a broad, customer/stakeholder identification list developed as part of a strategic planning or health improvement planning process, the health department must document how customer/stakeholder feedback was collected, analyzed, and conclusions drawn from two different types of customers (e.g., vital statistics customers; food establishment operators; individuals receiving population immunizations, population screenings, or other services; partners and contractors; elected officials, etc.).** Special effort to address those who have a language barrier, are disabled, or are otherwise disenfranchised must be included. Examples of instruments to collect customer/stakeholder satisfaction include forms, surveys, focus groups, or other methods. Documentation could be a report, memo, or other written document that describes the process and the results and conclusions of the analysis of the feedback.	**2 examples** Customers must be from two different programs	**5 years**
2. Results and actions taken based on customer feedback	**2. The health department must document results and action taken based on the collection, analysis, and conclusions drawn from feedback from customer groups.** Documentation must relate to the examples in Required Documentation above.	**2 examples**	**5 years**

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Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.5 A Opportunities provided to staff for involvement in the department's performance management	The purpose of this measure is to assess the health department's support to expand and enhance performance management capacity in the department.	For a health department to be effective in establishing and implementing a performance management system, the staff must understand what a performance management system is and how evaluation integrates with performance management. The department needs to ensure staff competence in the appropriate use of tools and techniques for monitoring and analyzing objectives and indicators.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Staff development in performance management	**1. The health department must document its staff professional development in the area of performance management.** At a minimum, targeted staff includes those who will be directly working on performance measure monitoring and analysis, and/or serving on a quality team that assesses the department's implementation of performance management practices and/or system. Documentation could be, for example, training attendance rosters, training curricula and objectives, presentations, participation in webinars, and other training materials, or specific work with consultants or technical assistants in performance management.	**2 examples**	**5 years**

Standard 9.1: Use a performance management system to monitor achievement of organizational objectives.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.1.6 S Technical assistance and/or training provided on performance management to Tribal and local health departments	The purpose of this measure is to assess the state health department's capacity to provide performance management orientation/training, evaluation training, and/or technical assistance to Tribal and local health departments.	State health departments have internal capacity or access to performance management and evaluation expertise to assist Tribal and local health departments in building or enhancing their performance management and evaluation capacity. States have an opportunity to share their expertise and best practice experiences with Tribal and local partners and create conditions in which the state's population benefits from locally improved processes, programs, and interventions.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Provision of technical assistance about performance management systems	**1. The state health department must document that it has offered technical assistance and/or training in performance management practices, methods, and/or tools to Tribal and local health departments.** The technical assistance can be provided "as requested," or can be scheduled, or provided as needed. It can be delivered by in-person sessions, webinars, individual studies, hard copy, or on-line. The technical assistance does not have to be used by Tribal or local health departments, but must be made available. Documentation could be, for example, attendance rosters, curricula, presentations, exercises to apply tools and techniques, newsletters, briefing papers, e-newsletters, email notification, or flyer or brochure distribution.	**2 examples**	**5 years**

STANDARD 9.2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions.

Performance management system concepts and practices serve as the framework to set targets, measure progress, report on progress, and make quality improvements. An important component of the performance management system is the implementation of a quality improvement program. This effort involves integration of a quality improvement component into staff training, organizational structures, processes, services, and activities. It requires application of an improvement model and the ongoing use of quality improvement tools and techniques to improve the public's health. Performance management leads to the application of quality improvement processes.

Quality improvement is the result of leadership support. It requires staff commitment at all levels within an organization to infuse quality improvement into public health practice and operations. It also involves regular use of quality improvement approaches, methods, tools, and techniques, as well as application of lessons learned from evaluation.

Standard 9.2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.2.1 A Established quality improvement program based on organizational policies and direction	The purpose of this measure is to assess the health department's efforts to develop a quality improvement program that is integrated into all programmatic and operational aspects of the organization.	To make and sustain quality improvement gains, a sound quality improvement infrastructure is needed. Part of creating this infrastructure involves writing, updating, and implementing a health department quality improvement plan. This plan is guided by the health department's policies and strategic direction found in its mission and vision statements, in its strategic plan, and in its health improvement plan.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. A written quality improvement plan	**1. The health department must provide a quality improvement plan.** The plan must address: • Key quality terms to create a common vocabulary and a clear, consistent message. • Culture of quality and the desired future state of quality in the organization. • Key elements of the quality improvement effort's structure, for example: -- Organization structure -- Membership and rotation -- Roles and responsibilities -- Staffing and administrative support -- Budget and resource allocation • Types of quality improvement training available and conducted within the organization for example: -- New employee orientation presentation materials -- Introductory online course for all staff	**1 plan**	**5 years**

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	-- Advanced training for lead QI staff -- Continuing staff training on QI -- Other training as needed – position-specific QI training (MCH, Epidemiology, infection control, etc.) • Project identification, alignment with strategic plan and initiation process: -- Describe and demonstrate how improvement areas are identified and how they are prioritized for project activity -- Describe and demonstrate how the improvement projects align with the health department's strategic vision/mission • Quality improvement goals, objectives, and measures with time-framed targets: -- Define the performance measures to be achieved. -- For each objective in the plan, list the person(s) responsible (an individual or team) and time frames associated with targets -- Identify the activities or projects associated with each objective. • The health department's approach to how the quality improvement plan is monitored: data are collected and analyzed, progress reported toward achieving stated goals and objectives, and actions taken to make improvements based on progress reports and ongoing data monitoring and analysis. • Regular communication of quality improvement activities conducted in the health department through such mechanisms as: -- Quality electronic newsletter -- Story board displayed publicly -- Board of Health meeting minutes -- Quality Council meeting minutes -- Staff meeting updates		

	• Process to assess the effectiveness of the quality improvement plan and activities, which may include: -- Review of the process and the progress toward achieving goals and objectives -- Efficiencies and effectiveness obtained and lessons learned -- Customer/stakeholder satisfaction with services and programs -- Description of how reports on progress were used to revise and update the quality improvement plan.		

Standard 9.2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 9.2.2 A Implemented quality improvement activities	The purpose of this measure is to assess the health department's use of quality improvement to improve processes, programs, and interventions.	It takes practice to effectively use the quality improvement plan to improve processes, programs, and interventions. Staff benefit from seeing the plan put into action and receiving regular feedback on progress toward achieving stated objectives, as well as on how well they have executed their respective roles and responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Quality improvement activities based on the QI plan	**1. The health department must document implementation of quality improvement activities and the health department's application of its process improvement model.** Examples must demonstrate: • how staff problem-solved and planned the improvement, • how staff selected the problem/process to address and described the improvement opportunity, • how they described the current process surrounding the identified improvement opportunity, • how they determined all possible causes of the problem and agreed on contributing factors and root cause(s), • how they developed a solution and action plan, including time-framed targets for improvement, • what the staff did to implement the solution or process change, and • how staff reviewed and evaluated the result of the change, and how they reflected and acted on what they learned.	**2 examples;** one example must be from a program area and the other from an administrative area.	**5 years**

	Documentation must demonstrate ongoing use of an improvement model, including showing the tools and techniques used during application of the process improvement model. Documentation must also describe: actions taken, improvement practices and interventions, data collection tools and analysis, progress reports, evaluation methods, and other activities and products that resulted from implementation of the plan. Documentation could be, for example, quality improvement project work plans or storyboards that identify achievement of objectives and include evidence of action and follow-up.		
2. Staff participation in quality improvement activities based on the QI plan	**2. The health department must document how staff were involved in the implementation of the plan, worked on improvement interventions or projects, and/or served on a quality team that oversees the health department's improvement efforts.** Documentation could be, for example minutes, memos, reports, or committee or project responsibilities listings.	**2 examples**	**5 years**

Domain 10: Contribute to and Apply the Evidence Base of Public Health

Domain 10 focuses on the role that health departments play in building and advancing the science of public health. Public health is strengthened when its practitioners continually add to the body of evidence for promising practices -- those practices that have the potential to become evidence-based over time. Health departments should employ evidence-based practices for increased effectiveness and credibility. Health departments also have important roles in developing new evidence. Health departments should apply innovation and creativity in providing public health services appropriate for the populations they serve.

DOMAIN 10 INCLUDES TWO STANDARDS:

Standard 10.1:	Identify and Use the Best Available Evidence for Making Informed Public Health Practice Decisions
Standard 10.2:	Promote Understanding and Use of the Current Body of Research Results, Evaluations, and Evidence-based Practices with Appropriate Audiences

STANDARD 10.1: Identify and use the best available evidence for making informed public health practice decisions.

Public health evidence-based practice requires that a health department use the best available evidence in making decisions and in ensuring the effectiveness of processes, programs, and interventions. Evidence-based practice assures that a health department's resources are being used in the most effective manner. Health departments should access information about evidence-based practices and apply that information to their processes, programs, and interventions.

Standard 10.1: Identify and use the best available evidence for making informed public health practice decisions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.1.1 A Applicable evidence-based and/or promising practices identified and used when implementing new or revised processes, programs, and/or interventions	The purpose of this measure is to assess the health department's use of evidence-based and/or promising practices in its design of new process, programs, or interventions or in revisions of programs.	It is important that public health efforts have the maximum positive impact possible. Evidence-based practices have been evaluated or researched and have been found to be effective. Health departments should be aware of practices that are evidence-based and incorporate them into their processes, programs, and interventions, as appropriate. Evidence-based practice ensures that health department resources are being applied effectively. Promising public health practices also have the potential for evaluation and designation as evidence-based.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The use of evidence-based or promising practices, including: a. Documentation of the source of the evidence-based or promising practice	**1. The health department must document the incorporation of an evidence-based or promising practice in a public health process, program, or intervention.** a. The health department must document the source of the information concerning the evidence-based or promising practice. The source of the practice could be (1) The Guide to Community Preventive Services, (2) an Initiative listed in the NACCHO Model Practices Database, (3) the result of an information search (web, library, literary review), or (4) result of interaction with consultants, academic faculty, researchers, other health departments, or other experts.	**2 examples;** examples must come from two different program areas, one of which is a chronic disease program or program that seeks to prevent chronic disease.	**3 years**

b. Documentation of how the evidence-based or promising practice was incorporated into the design of a new or revised process, program, or intervention	b. The health department must provide a description of how the evidence-based or promising practice identified in (a) above was incorporated into the design of a new or revised process, program, or intervention. Incorporation of the evidence-based or promising practice must be appropriate to the particular group or community or it must be modified to be appropriate. Documentation could be, for example, internal memos, annual reports, program descriptions in public information (reports, newsletters), or other program descriptions written by the department. Due to the limited availability of evidenced-based practices or promising practices in Tribal communities, Tribal health departments may provide documentation of how evidence-based practices or promising practices have been adapted to integrate cultural values, beliefs, and traditional healing practices of the Tribe.		

Standard 10.1: Identify and use the best available evidence for making informed public health practice decisions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.1.2 T/S Fostered innovation in practice and research	The purpose of this measure is to assess the Tribal or state health department's efforts to promote and support innovations in public health practice and research.	Public health addresses complex, multi- sectorial problems that are changing as rapidly as our social, cultural, and technological environment is changing. The need for innovation in public health practice and research is more urgent, given the increasingly rapid pace of change in the environment that affects the public's health.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Relationships with academic institutions, research centers/ institutes	**1. The Tribal or state health department must document that it has a working relationship with academic institutions, research centers/institutes, and/or Tribal organizations and Tribal Epidemiology Centers.** In some cases, the relationship may be a formal relationship that can be documented by a contract or a MOA/MOU. In other cases, the working relationship may be less formal. In those cases, documentation can be, for example, meeting minutes, emails, or a meeting agenda that demonstrates collaboration with academic institutions and/ or research centers/institutes. Additionally, jointly written reports, white papers, and research studies could demonstrate collaboration with academic institutions and/or research centers/institutes.	**2 examples**	**5 years**
2. Participation in research agenda-setting, practice-based research networks, or other research efforts	**2. The Tribal or state health department must document that it is engaged with the work of the research community.** The Tribal or state health department must demonstrate involvement of the community in the development of the research agenda. Documentation could be, for example, membership in a practice-based research network, either with other states, institutions, or within the state. Community Based Participatory Research is a model that could be used. For Tribal health departments, this may include the incorporation of practice-based evidence grounded in cultural values, beliefs, and traditional practices. Documentation could be, for example, a membership list or meeting attendance roster. Documentation could also be meeting minutes or submission of IRB documentation showing participation in research (minutes, submission documentation).	**2 examples**	**5 years**

STANDARD 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

Lack of communication or understanding between public health researchers and public health practitioners often exists. Gaps in understanding may also occur between the public health department and the general public. Communication can help bridge the areas where understanding is lacking and can strengthen the relationship and trust among researchers, public health practitioners, and the public. Communication between public health practitioners and the public, governing entities, and other audiences could encourage others to become advocates for research and to contribute to the science of public health. Health departments should encourage the use of research results, evaluations, and evidence-based practices.

Standard 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.2.1 A Protection of human subjects when the health department is involved in or supports research activities	The purpose of this measure is to assess the health department's policies and practices for the protection of human subjects in research in which it is involved.	Many public health studies involve recipients of public health services or public health staff. Institutions that receive government funds for research are required to have the research that involves human subjects approved by a registered institutional review board (IRB) to ensure the ethical treatment of human subjects. Ethical treatment of human subjects is a basic value of public health research and programs. Appropriate efforts must be made to protect the rights, welfare, and well-being of subjects involved in research.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. An adopted human subjects research protection policy	**1. The health department must provide a copy of a policy regarding research, such as an IRB review policy.** If the health department does not have its own internal IRB process, the health department must have a copy of the IRB approval from the institution where the IRB review was done. If the health department does not currently engage in research that involves human subjects, a statement to that effect could be accepted as documentation. Documentation for a Tribal health department could be a Tribal policy or protocol that describes the process for research review and approval by the Tribal Council, Health Oversight Committee, or other body or authority.	**1 policy**	**5 years**

Standard 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.2.2 A Access to expertise to analyze current research and its public health implications	The purpose of this measure is to assess the health department's ability to review and interpret research findings.	Health departments must have the internal capacity for, or ability to access, expert review and interpretation of research findings. Interpreting research findings is important when communicating the public health implications of those findings to stakeholders, partners, and the public. It is also important when incorporating research findings into department processes, programs, or interventions.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The availability of expertise (internal or external) for analysis of research	**1. The health department must document that it has expert staff or access to outside experts who can analyze research and its public health implications.** This measure includes analysis of the current body of research relevant to public health practice, irrespective of whether or not the research was conducted in the Tribe, state, or community. Documentation could be, for example, a list of experts and a description of their training or expertise. The expertise may be within the department or may reside outside the health department, for example, an academic institution, research center, Tribal epidemiology center, public health institute, or consultant. If the expertise is outside of the health department, the health department must show a written agreement (contract, MOA/MOU, etc.) that demonstrates access to such expertise.	**2 examples or one list**	**5 years**

Standard 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.2.3 A Communicated research findings, including public health implications	The purpose of this measure is to assess the health department's efforts to keep others, both within and outside the public health profession, informed about the findings of public health research and the public health implications of those findings.	Public health research provides the knowledge and tools that people and communities need to protect their health. However, research findings can be confusing and difficult to translate into knowledge that steers action toward improved public health. Health departments can communicate the facts and implications of research so that individuals and organizations are informed and knowledgeable, and can act accordingly.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The communication of research findings and their public health implications to stakeholders, public health system partners, and/or the public	**1. The health department must document the provision of communication through which the department conveyed research findings and their public health implications to stakeholders, other health departments, members of the public health system and non-public health system partners, and/or the public.** Appropriate audiences could include: the health department's governing entity; elected/appointed officials; agencies, departments, or organizations that collaborate with the health department in the delivery of services; community and healthcare partners; and the general public. Audiences would be especially appropriate if involved in or affected by the research. Community Based Participatory Research is an example of an approach that could be used. Research referred to is research conducted and published by others, outside of the health department. The research must have been evaluated by experts to provide valid implications, for example, peer-review for publication in journals. The state health department distribution list of research findings must include the Tribal and local health departments in the state. The local health department distribution list of research findings must include the state health department and Tribal health department(s) in the state with which the local health department coordinates.	**2 examples**	**5 years**

	The Tribal health department distribution list of research findings must include the state and local health department(s) in the state with which the Tribal health departments coordinates. Documentation could be, for example, a presentation, prepared report, discussion at a meeting recorded in the minutes, web posting, email list-serve, newspaper article, webinar, or press release.		

Standard 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.2.4 S Consultation or technical assistance provided to Tribal and local health departments and other public health system partners in applying relevant research results, evidence-based and/or promising practices	The purpose of this measure to assess the state health department's provision of assistance to Tribal and local health departments on the application of relevant research results and evidence-based/ promising practices.	Scientifically sound public health practices are essential for public health interventions to be effective. Public health practices are continually being researched and tested, and new findings are being made available to the field. State health departments should share their knowledge and expertise concerning research findings and evidence-based or promising practices with Tribal and local health departments in their state. State health departments can provide consultation or technical assistance on employing research and modifying practices to best suit the population served by the Tribal or local health department.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Provision of consultation or technical assistance to Tribal and/or local health departments, and/or other public health system organizations in applying relevant research, evidence-based, and/or promising practices	**1. The state health department must document how it has provided consultation, technical assistance, advice, direction, or guidance to Tribal and/or local health departments and/or members of the public health system in the application of relevant research, evidence-based, and/or promising practices.** This assistance must be specific to the application of relevant research results or the employment of evidence-based and/or promising practices. This assistance can be provided to local health departments, Tribal health departments in the state, or other partners or stakeholders. The state health department cannot use examples of providing assistance to program divisions within the state health department.	**2 examples**	**5 years**

Standard 10.2: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 10.2.4 T Technical assistance provided to the state health department, local health departments, and other public health system partners in applying relevant research results, evidence-based and/or promising practices	The purpose of this measure to assess the Tribal health department's provision of assistance to the state and local health departments and other Tribal health departments on the application of relevant research results and evidence-based/promising practices.	Scientifically sound public health practices are essential for public health interventions to be effective. Public health practices are continually being researched and tested, and new findings are being made available to the field. Tribal health departments should share their knowledge and expertise on research findings and evidence-based or promising practices with state and local health departments, other Tribal health departments, and/or Tribal organizations. Tribal health departments can provide consultation or technical assistance on employing research and modifying practices to best suit the population being served. Tribal health departments should share with state and local health departments their knowledge and expertise on research methods that are culturally relevant or appropriate approaches to applying research in Tribal communities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Provision of consultation or technical assistance to state and/or local health departments, other Tribal health departments, and/or Tribal organizations in applying relevant research, evidence-based, promising practices, and/or practice-based evidence	**1. The Tribal health department must document the provision of consultation, technical assistance, advice, direction, or guidance to others in the application of relevant research or evidence-based, promising practices, and/or practice-based evidence.** This assistance must be specific to the application of relevant research results or the employment of evidence-based and/or promising practices. This assistance can be provided to the state health department, local health departments, other Tribal health departments or Tribal organizations in the state, or other partners or stakeholders. Examples of technical assistance provided by the Tribe may be done together with a federal partner, such as IHS, a Tribal Epidemiology Center, or other Tribal department. The Tribal health department cannot use examples of providing assistance to itself, such as to program divisions within the Tribal health department.	**2 examples**	**5 years**

Domain 11: Maintain Administrative and Management Capacity

Domain 11 focuses on health department management and administration capacity. Organizational administration and management is the process of organizing, leading, and controlling the efforts of organizational human and other resources to make decisions and achieve organizational goals. Health departments must have a well-managed human resources system, be competent in general financial management, have data management capacity and capability, and be knowledgeable about public health authorities and mandates. And, because of the nature of public health – the focus on the collective good, the employment of government action, and the objective of population-based outcomes – public health leaders need an infrastructure to ensure that decisions, policies, plans, and programs are ethical and address health equity. Health department leaders and staff must be knowledgeable about the structure, organization, and financing of their public health department and other agencies and organizations that provide public health services.

DOMAIN 11 INCLUDES TWO STANDARDS:

Standard 11.1:	Develop and Maintain an Operational Infrastructure to Support the Performance of Public Health Functions
Standard 11.2:	Establish Effective Financial Management Systems

STANDARD 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

A strong operational infrastructure is necessary in order to administer public health services efficiently and effectively to meet the needs of the population. By maintaining a strong organizational infrastructure, the health department can assess and improve its operations, staffing, and program support systems.

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.1 A Policies and procedures regarding health department operations, reviewed regularly, and accessible to staff	The purpose of this measure is to assess the health department's processes for maintaining policies and procedures, which includes developing, writing, reviewing, revising, training, and sharing health department policy and procedures with staff. This measure focuses on health department policies that direct organizational operations, not programs and program guidelines.	Standardized written policies and procedures are needed to operate an organization efficiently and effectively. Regular review and revision of those policies and procedures is important for continuous quality improvement. Staff needs to have ready access to policies and procedures to be informed of organizational and operations expectations.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Policy and procedure manual or individual policies	**1. The health department must provide written operations policies/ procedures.** This could be one manual or a group of policies. These are operations policies, not human resource policies, which are addressed in Measure 11.1.5. Policies could address these topics, for example, records retention and back-up procedures, reimbursement, invoicing, emergency/ evacuation, events planning, procurement of office supplies, facilities operations, use of department equipment (including phones and internet), use of department vehicles, tobacco use, recycling, scheduling the use of meeting rooms, the development of policies that includes who needs to sign what types of policies and how often they are reviewed, and any policies and procedures that concern the operations of the department. The policies can be provided to staff in paper form, on a central computer file, or a link to an electronic format. If electronic, the policies can be files on a server or postings on the web. If the policies are voluminous, the health department may provide a Table of Contents or list of policies.	**1 Manual or, if a Table of Contents or list is provided, 2 example policies are also required.**	**5 years**

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	Only the most recent version of policies must be provided. Some health departments may use policies and procedures that are not specific to the health department, but are government-wide (i.e., state, city or county) or relate to a larger super-health agency or umbrella agency. These policies and procedures could demonstrate compliance with the measure if they apply to the health department as well as other government agencies.		
2. Health department organizational chart	**2. The health department must provide its health department organizational chart.** If the health department is part of a super-agency or umbrella agency, and some of the documentation provided is from other divisions within the umbrella agency, then an organizational chart showing the health department's relationship with the other divisions is also required. The health department's organizational chart must show leadership, upper management positions, and the organization of programs. It need not detail every staff person. Position titles or program names are required; individuals' names are not required. If changes are made to the organizational chart between the submission of documentation to PHAB and the site visit, the health department must submit a copy of the revised chart to the site visit team. NOTE: This and the budget are the only two instance where information may be changed or updated between the submission of the health department's documents to PHAB and the time of the site visit.	**1 organizational chart**	**2 years**
3. Review of policies and procedures	**3. The health department must document the review of policies and procedures.** The original policies and procedures may have been in place for many years; official dates of policy revisions demonstrate that a review has been conducted within the last five years. Documentation could be policies that were adopted longer than 5 years ago but that have been reviewed, revised, and signed off on by the health department within the last five years.	**2 examples**	**5 years**
4. Methods for staff access to policies	**4. The health department must document how staff access policies.** Access methods can include for example, the website; health department intranet; server access; or paper copy distributed to staff, available from supervisors, or located in central locations.	**1 example**	**5 years**

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Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.2 A Ethical issues identified and ethical decisions made	The purpose of this measure is to assess the health department's policies and process for the identification and resolution of ethical issues that arise from the department's program, policies, interventions, or employee/employer relations.	Efforts to achieve the goal of protecting and promoting the public's health have inherent ethical challenges. Employer/employees relations may also raise ethical issues. Understanding the ethical dimensions of policies and decisions is important for the provision of effective public health and public health management. Defining and addressing ethical issues should be handled through an explicit, rigorous, and standard manner that uses critical reasoning.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Strategies for decision making relative to ethical issues	**1. The health department must document the identification of issues with ethical considerations and a strategic deliberative process for consideration and resolution of ethical issues.** The policies and procedures must set forth a transparent process that provides an opportunity for input from affected stakeholders and considers their interests. The policies and procedures must provide for the consideration of the best evidence available. There must be opportunities to evaluate decisions as new information becomes available and there must be a provision for accountability of the decision makers. Examples of a process include the adoption of the Public Health Code of Ethics, the establishment of an ethics board, the designation of a committee or process of the governing entity, or other process.	**1 process or set of policies and procedures**	**5 years**
2. Ethical issues reviewed and resolved	**2. The health department must document the consideration, deliberation, and resolution of ethical issues.** Examples of ethical issues include, for example, privately constructed sewers, distribution of vaccine in a shortage situation, staff mandatory immunizations, an employee's use of social media, an employee's acceptance of gifts.	**1 example**	**5 years**

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.3 A Policies regarding confidentiality, including applicable HIPAA requirements	The purpose of this measure is to assess how the health department protects customer confidentiality.	It is critical that health departments and the individuals who work in them maintain customer confidentiality and protect client health information. Lack of attention to confidentiality policies and their implementation can lead to violations of confidentiality. This creates liability to the health department and lessens credibility.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Confidentiality policies	**1. The health department must provide written confidentiality policies and procedures.** Policies must define the health department's processes for protecting customer confidentiality, both personal (directed toward the individual) and informational (directed at their health data and records). This may include policies concerning such processes as clinical protocols, staff access to records, computer use, business associate agreements, and electronic transfer of data. Policies may be maintained as either a paper copy or in an electronic format. If electronic, the policies can be files on a server or posted on the web. Some health departments may use confidentiality policies and procedures that are not specific to the health department, but are government-wide (i.e., state, city or county) or relate to a larger super-health agency or umbrella agency.	**1 policy or a set of policies**	**5 years**
2. Training staff on the implementation of confidentiality policies	**2. The health department must document that staff has been trained on confidentiality policies, including training content and names of those who received the training.** Documentation could be, for example, a copy of training materials and an agenda for the training session – whether group or individual. The health department must have a record of who attended the training. Documentation could also be a log, a sign-in sheet or a record/statement from web-based training.	**2 examples of training**	**5 years**

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3. Signed employee confidentiality form, as required by policies	**3. The health department must provide a confidentiality form or agreement that is signed by employees.** Through this form, staff will acknowledge their responsibilities for protecting confidentiality. The health department can submit a copy of the form. Do not submit copies of every employee-signed form; a log or other tracking mechanism showing that employees have signed the form is sufficient.	**1 form and 1 example of a tracking form or log**	**5 years**

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.4 A Policies, processes, programs, and interventions provided that are socially, culturally, and linguistically appropriate to specific populations with higher health risks and poorer health outcomes.	The purpose of this measure is to assess the health department's social, cultural, and linguistic competence in providing public health programs to specific populations with higher health risks and poorer health outcomes.	Public health departments are responsible for all residents in the health department's jurisdiction, and that usually includes people of various backgrounds, languages, and cultures. It is important for health departments to understand how values, norms, and traditions of the populations served affect how individuals perceive, think about, and make judgments about health, health behaviors, and public health services. Those values, norms, and traditions affect how populations interact with public health workers, how open they are to health information and health education, and how they can change health behaviors. Ensuring that the health department's policies, programs, services, materials, and processes address these social, cultural, and language differences (including low literacy, non-English speaking populations, and the visually or hearing impaired) will enhance the health department's ability to provide the most effective programs and services to meet the needs of the population. Ensuring that the health department's policies, programs, services, materials, and processes intentionally address health disparities and health inequities will enhance the health department's ability to impact the health of the population.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Policy or procedure for the development of interventions and materials that address areas of health inequity among the specific populations and are culturally and linguistically appropriate for the population the health department serves in its jurisdiction	**1. The health department must provide a policy or procedure that demonstrates how health equity is incorporated as a goal into the development of policies, processes, and programs.** A policy or procedure must ensure that social, cultural, and linguistic characteristics of the various populations groups of the population it serves are incorporated into processes, programs, and interventions. Characteristics of populations addressed in the policy or procedure may include social, racial, ethnic, cultural, sexual orientation and gender identity, linguistic characteristics, including non-English speaking populations, and the disabled.	**1 policy or procedure**	**5 years**

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2. Processes, programs, or interventions provided in a culturally or linguistically competent manner	**2. The health department must document the provisions of processes, programs, or interventions that are culturally or linguistically appropriate, as defined above.** Oral communication is integral to many Tribal cultures. If oral communication is used to ensure that programs, processes, and interventions are culturally competent, the health department must provide documentation of its use, for example, plans, protocols, or objectives for focus groups, community gatherings, roundtables, talking circles, digital storytelling, or other activities. Tribal health departments may serve Tribal members from more than one Tribe or non-Tribal individuals. If this is the case, examples of culturally and linguistically competent services provided to these groups. (e.g., interpretation, materials in other languages) are acceptable documentation.	**2 examples;** The two examples must come from two different program areas of the health department	**5 years**
3. Assessment of the health department's cultural competence and knowledge of health equity	**3. The health department must provide an assessment of cultural and linguistic competence.** This could be, for example, the Cultural and Linguistic Competency Policy (CLCPA) self-assessment from the National Center for Cultural Competence, assessment against Culturally and Linguistically Appropriate Services (CLAS) standards, Health Equity at Work: Skills Assessment of Public Health, or another assessment tool.	**1 example**	**5 years**
4. Health equity and cultural competency training provided to health department staff	**4. The health department must document staff training on health equity and cultural competence, including social, cultural, and/or linguistic aspects of policies, processes and programs.** Training may include: examining biases and prejudices; developing cross-cultural skills; learning about specific populations' values, norms, and traditions; and/or learning about how to develop programs and materials for low literacy individuals or the visually or hearing impaired. Documentation must show the content of the training. The health department must provide a record of who attended the training. This may be a log, a sign-in sheet, or a record/statement from web-based training. An example of training includes the Prevention Institute's Health Equity Training Series. Documentation could be, for example, a copy of the training materials or an agenda for the training session as well as a sign-in sheet or attendance list.	**1 example**	**5 years**

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.5 A A human resources function	The purpose of this measure is to assess the health department's management of its human resources. A comprehensive human resource function may be fully contained within the health department or it may be located in its own governmental agency (for example, an office of management), in an office outside the health department, or may be implemented in a combination of ways. If the larger human resources system is outside of the health department, the health department still must perform human resources management functions, for example, ensuring that human resource policies are available to staff, keeping time sheets, managing leave, and conducting employees' performance evaluations. A health department may also contract for certain human resource actions to an outside organization that specializes in human resource management functions.	A well-defined and structured human resources function is important for any organization. It provides the health department with the management processes to hire, manage, evaluate personnel, and improve personnel performance. A human resource function supports the health department, individual staff members, staff development, and the overall workplace environment.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Human resource (HR) policies and procedures	**1. The health department must provide a human resource manual or set of policies and procedures.** The policies and procedures must address all of the following: • Employment and human resources legal requirements that pertain to the jurisdiction served by the health department (Tribal, state, and/or local); • Personnel recruitment, selection, and appointment; • Employee confidentiality; • Equal opportunity employment; • Salary structure; • Hours of work; • Benefits package; • Performance evaluation process based on job/position descriptions and individualized development plans; and • Problem solving and complaint handling, including sexual harassment. Some health departments may use a human resource system that is not specific to the health department, but is government-wide (i.e., Tribe, state, city, or county).	**1 set of HR policies and procedures**	**5 years**

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	The policies and procedures may not, therefore, be specific to only the health department but to all of city, county, state, or Tribal government. These policies and procedures could demonstrate compliance with the measure if they apply to the health department, as well as other government agencies. Indian Preference Policies may be submitted in place of personnel selection and appointment and/or Equal Opportunity Employment policies. It may also be applicable that Tribal health departments provide MOAs for assignment of personnel [e.g., U.S. Public Health Service/Indian Health Service or other personal service contracts or agreement (PSA)].		
2. Staff access to human resource policies and procedures	**2. The health department must document how department staff access human resource policies and procedures.** Methods may include, for example, web-based, health department intranet, server access, or distribution of a hard copy that is available from supervisors or located in central locations.	**1 example**	**5 years**
3. Employment working relationship agreements	**3. The health department must provide documents in use to establish working relationships.** Examples of documents used to establish working relationships include, for example, employment agreements, contract template, letter of employment template, contracts, or labor agreements (if appropriate).This does not include contracts for service.	**1 example**	**5 years**
4. A human resource function that supports management, the workforce, and workforce development by being a responsive partner to programs	**4. The health department must document that the human resource function demonstrates a responsive partnership with management, programs, services, and staff to enable staff that provide public health programs, services, and products.** Documentation could be, for example, the human resource function and a program collaboratively resolving a human resource issue, human resource staff that are educated/experienced in public health (for the purpose of assessing workforce needs, enabling workforce development, and recruiting candidates for public health positions), human resource policies that support the public health program functions, and programs and the human resource function working together to develop policies and provide training and development.	**2 examples**	**5 years**

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.6 A Information management function that supports the health department's mission and workforce by providing infrastructure for data storage, protection, and management; and data analysis and reporting	The purpose of this measure is to assess the health department's capacity and capability to store, manage, protect, and utilize electronic information and data in order to provide relevant information for operational efficiency and informed decision making.	Effective public health decisions require accurate information and data. Health departments have access to a wealth of data, either created by the department or collected by others. To use data effectively, the health department must organize and process data in a manner to appropriately protect data and also make it available for decision making. The health department must maintain an information management system that provides the ability to store, protect, process, manage, analyze, utilize, and communicate information and data available from multiple sources.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Information technology infrastructure that supports public health functions	**1. The health department must document that information technology supports public health and administrative functions of the department.** Documentation could be, for example, a scanning system to preserve records, a grant management system, vital records systems, program (such as WIC or immunization) information systems, licensing information systems, inspections and violations records, and on-line data services.	**2 examples;** The two examples must be from different areas. The health department may select the areas. They may be program and/or administrative areas.	**5 years**

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2. Secure information systems	**2. The health department must document information vulnerability audits, security policies, and/or internal controls to ensure the privacy and security of information.**	**1 example**	**3 years**
3. Maintenance of confidentiality of data	**3. The health department must provide a policy that the department adheres to federal, state, and local privacy protection regulations for handling data.**	**1 policy**	**5 years**
4. Maintenance of information management system	**4. The health department must provide a written process for reviewing and developing information management business system requirements to guide systems changes and development.**	**1 example**	**5 years**
5. Management of information assets	**5. The health department must provide an inventory of data or data systems (either collected by the health department or by others) available to the health departments.**	**1 example**	**3 years**

Standard 11.1: Develop and maintain an operational infrastructure to support the performance of public health functions.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.1.7 A Facilities that are clean, safe, accessible, and secure	The purpose of this measure is to assess the health department's facilities for use by both staff and the public.	In order for the health department to implement processes, programs, and interventions, the facilities must be adequate. All facilities that are operated by the health department must be clean, safe, accessible, and secure for both staff and the public.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Licenses for laboratory	**1. The health department must provide copies of licenses to meet national or state requirements appropriate for the laboratory services provided.** Access to a laboratory that has Select Agent certification is required.	**As needed**	**5 years**
2. Inspection reports	**2. The health department must provide examples of inspection reports, for example, OSHA, internal (department conducted), or external (an independent organization) inspection reports, cleaning and maintenance policies, logs, records, certificate of occupancy, contracts or orders.** Other examples of documentation include environmental public health and safety committee meeting minutes and federal or Tribal environmental audits.	**2 examples**	**5 years**
3. Assurance of accessibility to the health department's facilities	**3. The health department must provide documentation that it is in compliance with Federal/state/local laws concerning accessibility.** PHAB will accept a copy of the ADA compliance report or the health department's self-evaluation, as described by federal regulations. PHAB will accept documentation of compliance with ADA related Tribal, state, and/or local laws and regulations that pertain to the jurisdiction which the health department is authorized to serve. For health departments that may operate in buildings that are either exempt from the federal regulations or have waivers (such as buildings on the national register of historic buildings), PHAB requires documentation of the health department's procedures to serve members of the public and health department staff who have physical disabilities, are sight impaired, or are hearing impaired.	**1 example**	**5 years**

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STANDARD 11.2: **Establish effective financial management system.**

Sound financial practices are basic to any organization. They are required to manage resources wisely, to analyze present and future needs, to sustain operations, and demonstrate accountability. This standard measures the capacity of the health department to manage the organization's finances.

Standard 11.2: Establish effective financial management system.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.2.1 A Financial and programmatic oversight of grants and contracts	The purpose of this measure is to assess the health department's ability to manage grants and contracts and comply with external governmental funding requirements.	Health departments receive funding from a variety of sources. Each funding source has specific requirements for the use of the funds and for reporting to the funding agency. It is important that funds are used appropriately and legitimately and that the health department has systems for accountability.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Audited financial statements	**1. The health department must provide regular (as defined by the health department) department-wide financial audit reports.** Audits are formal examinations of the health department's financial accounts. Audits are performed by external auditors. The health department's audit may be part of a large audit of the governmental unit (for example, umbrella agency, super agency, county government, or state government) of which the health department is a part.	**2 examples**	**Previous two fiscal years**
2. Program reports	**2. The health department must provide program reports that it has submitted to funding organizations.** Documentation could be, for example, compliance reports to federal funders, reports to legislatures or local city/county/Tribal councils, and reports to foundations. Monitoring reports or corrective action plans that show compliance with funding requirements are also acceptable. Contracts or agreements between state, local, and/or Tribal health departments to provide services may show the expectations for funding but might not show the compliance with funding agency requirements. If such contracts are used, they must be combined with follow-up reports that validate compliance.	**2 examples**	**5 years**

3. Communications from federal or state funding agencies or organizations	**3. The health department must provide any formal communications from state or federal funders that indicate the health department is a "high-risk grantee."** Disclosure and documentation must be provided in the following types of instances: the department being put on manual draw-down; the department being put on a corrective action plan; placement on a 'do not fund' list; receivership status; and instances of malfeasance or misappropriations of funds. Documentation could be letters or emails that officially and formally describe concerns from funding agencies (e.g., federal agencies, state health department funding to local health departments). Documentation must also include a description of follow-up actions and internal controls that have occurred to remedy the situation. If there have been no communications regarding "high-risk grantee" status, the health department director must provide a signed statement attesting to that fact.	**All, as appropriate**	**5 years**

Standard 11.2: Establish effective financial management system.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.2.2 A Written agreements with entities from which the health department purchases, or to which the health department delegates, services, processes, programs, and/or interventions	The purpose of this measure is to assess the health department's management of agreements with other organizations to provide services, processes, programs, or interventions on behalf of the health department.	The health department may not directly deliver or provide all services and administrative activities. They may depend on other entities to act on its behalf. These services could be related to organizational, management, and administrative functions, or to program services or interventions delivered to the public.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Contracts/MOUs/ MOAs or other written agreements for the provision of services, processes, programs, and/or interventions	**1. The health department must provide contracts or MOU/MOAs or other written agreements that have been executed with other organizations or departments.** State health department documentation could be, for example, a written agreement with a local or district health department for one of the examples. The other example must be with another agency or organization. Local health department documentation could be a written agreement with the state health department for one of the examples. The other example must be with another agency or organization. Tribal health department documentation could be a written agreement with a local, district, or state health department for one of the examples. The other example must be with another agency or organization. Tribal health departments may use the compact or funding agreement with the U.S. DHHS to carry out programs of the Indian Health Service. Also acceptable for documentation: agreements with non-Tribal entities to provide Contract Health Services (CHS) to beneficiaries of the Tribal health department, as well as MOA/MOUs or other agreements with other entities, such as epidemiological services provided to Tribes from Regional Epidemiologic Centers funded by IHS.	**2 examples;** the examples must be from two different program/ administrative areas featuring written agreements with different entities	**2 years**

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Standard 11.2: Establish effective financial management system.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.2.3 A Financial management systems	The purpose of this measure is to assess the health department's ability to manage finances.	Sound management of financial resources is a basic function of a public health department. Health departments are accountable to their governing entity, elected officials, and the public they serve for the responsible use and oversight of public funds.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Approved health department budget	**1. The health department must provide the approved budget that is in effect when the documentation for accreditation is submitted to PHAB.** The budget may be approved by the governing entity or other body with approval authority, such as a governor's budget office. If a new budget is approved between the submission of documentation to PHAB and the site visit, the health department must provide a copy of the new budget to the Site Visit Team. NOTE: The budget and the organizational chart are the only two instances where information may be changed or updated between the submission of the health department's documents to PHAB and the time of the Site Visit.	**1 budget**	**2 years**
2. Financial reports	**2. The health department must provide quarterly financial reports.** The examples provided may demonstrate two different types of reporting or may be two successive reports of the same type. Documentation could be, for example, expense reports, reimbursement reports, reports to governing entities, and/or monthly budget reports – summarized or itemized.	**2 examples**	**5 years**

Standard 11.2: Establish effective financial management system.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 11.2.4 A Resources sought to support agency infrastructure and processes, programs, and interventions	The purpose of this measure is to assess the health department's activities to increase financial resources to support its infrastructure and to enhance or develop processes, programs, and interventions.	Additional funding to support public health processes, programs, and interventions should be sought through a variety of means, including budget increase requests, budget revision requests, and grants. Financial resources should be maximized by leveraging current funds to increase resources available for public health.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Formal efforts to seek additional financial resources	**1. The health department must provide grant applications (funded or unfunded) or must document the leveraging funds to obtain additional resources (for example, providing matching funds).**	**2 examples**	**5 years**
2. Communications concerning the need for financial support to maintain and improve public health infrastructure and services	**2. The health department must document its communication concerning the need for additional investment in public health.** Communication could address a specific issue or address public health in general. Documentation could be, for example, articles or letters to the editor of a newspaper, presentations to the community, or testimony to elected officials. Tribal health department documentation could be, for example, Tribal letters or resolutions of support, Tribal public health assessments for the purpose of demonstrating resources needed, or executive order adding resources.	**2 examples**	**5 years**

Domain 12: Maintain Capacity to Engage the Public Health Governing Entity

Domain 12 focuses on the health department's support and engagement of its governing entity in maintaining and strengthening the public health infrastructure for the jurisdiction served. Governing entities both directly and indirectly influence the direction of a health department and should play a key role in accreditation efforts. However, much variation exists regarding the structure, definition, roles, and responsibilities of governing entities.

A governing entity, as it relates to the accreditation process, should meet the following criteria:

1. It is an official part of Tribal, state, or local government.
2. It has primary responsibility for policy-making and/or governing a Tribal, state, or local health department.
3. It advises, advocates, or consults with the health department on matters related to resources, policy making, legal authority, collaboration, and/or improvement activities.
4. It is the point of accountability for the health department.
5. In the case of shared governance (more than one entity provides governance functions to the health department), the governing entity, for accreditation purposes, is the Tribal, state, regional, or local entity that, in the judgment of the health department applying for accreditation, has the primary responsibility for supporting the applicant health department in achieving accreditation.

DOMAIN 12 INCLUDES THREE STANDARDS:

Standard 12.1:	Maintain Current Operational Definitions and Statements of the Public Health Roles, Responsibilities, and Authorities
Standard 12.2:	Provide Information to the Governing Entity Regarding Public Health and the Official Responsibilities of the Health Department and of the Governing Entity
Standard 12.3:	Encourage the Governing Entity's Engagement In the Public Health Department's Overall Obligations and Responsibilities

STANDARD 12.1: Maintain current operational definitions and statements of public health roles, responsibilities, and authorities

A health department operates with specific authorities to protect and preserve the health of the population within its jurisdiction. These authorities may be set forth in state statute, rules and regulation, local ordinances, administrative code, charters, or resolutions. Authorities may be regulatory and/or programmatic. This standard assures that the health department understands its authority, roles, and responsibilities and that of its governing entity, that such authority is put into practice, and that the governing entity is informed and engaged.

Standard 12.1: Maintain current operational definitions and statements of public health roles, responsibilities, and authorities.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.1.1 A Mandated public health operations, programs, and services provided	The purpose of this measure is to assess the health department's knowledge of and provision of the operations, programs, and services that it is mandated to provide.	Each health department has a set of mandated operations, programs, and services that it provides to protect and preserve the health of the population within the jurisdiction it serves. It is important that the health department is knowledgeable of these mandates and performs them as required.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Authority to conduct public health activities	**1. The health department must provide a copy of the body of law (statutes, rules, regulations, ordinances) that sets forth its mandated public health operations, programs, and services or a listing of mandated public health services and the reference to the legal citation.** The health department must make copies or access to the laws and regulations available to the Site Visit Team. For example, the health department could provide the disease reporting rules or regulations reflected by the Council of State and Territorial Epidemiologist's list of Nationally Notifiable Conditions; mandates for vaccinations; mandated oversight of environmental public health conditions, for example, solid waste, small public water systems, underground storage tanks, and hazardous materials; and various inspection programs, such as restaurant inspections. Tribal health departments could provide a Tribal resolution, ordinance, or executive order.	**1 example**	**5 years**
2. Operations that reflect authorities	**2. The health department must document how it implements its mandated processes, programs, or interventions.** Documentation could be, for example, service descriptions, annual reports, reports to the governing entity, meeting minutes, reports to governance, functional descriptions, organizational descriptions, or other written material.	**1 example**	**5 years**

Standard 12.1: Maintain current operational definitions and statements of public health roles, responsibilities, and authorities.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.1.2 A Operational definitions and/or statements of the public health governing entity's roles and responsibilities	The purpose of this measure is to assess the health department's knowledge of the governing entity's operational definition and/or governing entity's roles and responsibilities.	The governing entity is the point of accountability for the health department. The health department should have a clear understanding of the governing entity's structure, responsibilities, and expectations.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. The governing entity's authority	**1. The health department must provide a description of the governing entity and formal written statement of the governing entity's authority.** The governing entity could be, for example, a board of health, a governor's office, county commissioners, or other point of accountability. Documentation could be a copy of the body of law (for example, statutes, rules, regulations, ordinances, charter) that sets forth the mandated authority or a description of the authority and the reference to the legal citation. Tribal health department documentation could be aTribal resolution, ordinance, or executive order.	**1 or more documents, as required**	**No date restriction**
2. The governing entity's structure and composition	**2. The health department must provide a written description of the governing entity.** The governing entity could be, for example, a board of health, a governor's office, county commissioners, or other point of accountability. Documentation could be, for example, a statute, rules, regulations, a charter, an official charge statement, or other formal written document.	**1 example**	**No time restriction**

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STANDARD 12.2: Provide information to the governing entity regarding public health and the official responsibilities of the health department and of the governing entity.

The governing entity is the point of accountability for the health department. The governing entity is accountable for the health department achieving its mission, goals, and objectives to protect and preserve the health of the population within its jurisdiction. This standard addresses the health department's capacity for keeping the governing entity knowledgeable of the department's overall legal authority, obligations, and responsibilities, and on the governing entity's supporting role.

Standard 12.2: Provide information to the governing entity regarding public health and the official responsibilities of the health department and of the governing entity.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.2.1 A Communication with the governing entity regarding the responsibilities of the public health department and of the responsibilities of the governing entity	The purpose of this measure is to assess the health department's education of and communications with its governing entity regarding the health department's responsibilities and the roles and responsibilities of the governing entity.	Governing entities significantly influence the direction of health departments through policy making and other similar activities. Many governing entities have key roles in resource allocation, policy making, legal authority, collaboration, and/or quality improvement activities. As a result, they may heavily influence whether health departments are fulfilling their responsibilities. The governing entity, to be an effective advocate for public health and for the agency, must be aware of its responsibilities and duties and of the health department's roles and responsibilities.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Communication with the governing entity regarding the responsibilities of the public health department	**1. The health department must document communications provided to the governing entity concerning the health department's responsibilities, as set forth in the health department's authorizing document(s).** Documentation must demonstrate the process of informing the governing entity about the responsibilities of the health department. The health department will select its documentation for this measure based on the model of governance in place for the health department. Documentation could be, for example, reports, testimonies, speeches, presentations, or emails.	**2 examples for a; 1 process for b**	**5 years**
a. Communication with the governing entity about its operational definitions and/or statements of the public health governing entity's roles and responsibilities	a. The health department must document its sharing with the governing entity operational definitions and/or statements of the public health governing entity's public health related roles and responsibilities. The health department will select its documentation based on and appropriate to the health department's model of governance. Documentation could be, for example, meeting minutes, memos, emails, briefing papers, or other correspondence.		

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b. The orientation process for new members of the governing entity	b. The health department must document its process for orientation of new members of the governing entity. New member orientation must include both the responsibilities of the health department and of the governing entity. Documentation could be, for example, orientation agenda, meeting minutes, orientation materials.		

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STANDARD 12.3: Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities.

Public health governing entities exercise a wide range of responsibilities, including policy development, resource stewardship, legal authority, partner engagement, continuous improvement, and oversight. Specific areas of responsibilities may include, strategic planning, adopting and ensuring enforcement of public health regulations, ensuring that the governing body and health department act ethically, serving as a strong link between the health department and the community and other community organizations, supporting a culture of quality improvement, hiring and evaluating the health department director, taxing authority, and budget adoption. These responsibilities demand that the governing entity is well-versed in public health and in the work of the health department and the health challenges of the community. The governing entity and the health department should communicate regularly on the health of the community, strategic plan implementation, program activities, health department policy issues, public health ethical issues, and quality improvement activities.

Standard 12.3: Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.3.1 A Information provided to the governing entity about important public health issues facing the community, the health department, and/or the recent actions of the health department	The purpose of this measure is to assess health department efforts to keep the governing entity informed of public health issues and health department activities.	The health department has a responsibility to communicate with its governing entity to ensure that the governing entity's policies and decisions are informed. A regular flow of information helps to ensure that the governing entity acts in the best interests of the public's health. Information also needs to flow from the governing entity to the health department to ensure mutual understanding of policy options and implications.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Communication with the governing entity regarding important public health issues and/or recent actions of the health department	**1. The health department must document communications with the governing entity regarding important public health issues and/or recent actions of the health department.** Important public health issues include a population's health status, health indicators, health equity and disparities, disease outbreaks, environmental health hazards, etc. Documentation could be reports, testimonies, formal meeting minutes, meeting summaries, program updates, reports on identified public health hazards, community health assessment findings, community dashboards, outbreak and response efforts, annual statistical reports, or other written correspondence (memos, emails).	**2 examples**	**2 years**

Standard 12.3: Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.3.2 A Actions taken by the governing entity tracked and reviewed	The purpose of this measure is to assess the health department's familiarity and awareness of the governing entity's actions in order for the health department to identify patterns of issues discussed and topics or areas that call for increased communication and information.	It is important that the health department understand the priorities, policy positions, opinions, and actions of the governing entity in order to continually improve communication and effectiveness, leading to a quality governing entity-health department relationship.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Consistently review issues discussed, actions taken, and policies set by the governing entity	**1. The health department must document that it has consistently reviewed the governing entity's1) patterns of issues discussed; 2) opinions of the governing entity members; and/or 3) positions taken.** This will highlight topics or issue areas where increased communication is desirable. Review must be done at least annually. Documentation could be, for example, health department meeting minutes, reports, dashboards, presentations, memos, or other record of health department leadership's discussion of governing entity actions.	**2 examples**	**14 months** Examples do not need to be from different years.

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Standard 12.3: Encourage the governing entity's engagement in the public health department's overall obligations and responsibilities.

MEASURE	PURPOSE	SIGNIFICANCE
Measure 12.3.3 A Communication with the governing entity about health department performance assessment and improvement	The purpose of this measure is to assess the health department's communication with the governing entity on the overall assessment and improvement of the performance of the health department.	The governing entity should be knowledgeable about the health department's overall assessment and quality improvement initiatives. The governing entity will be in a better position to guide, advocate for, and engage with the health department if it is aware of improvements being undertaken.

REQUIRED DOCUMENTATION	GUIDANCE	NUMBER OF EXAMPLES	DATED WITHIN
1. Communication with the governing entity concerning assessment of the health department's performance	**1. The health department must document communications with the governing entity on plans and processes for improving health department performance.** The health department will select its documentation for this measure based on the model of governance in place for the health department. Communication efforts could include, for example, program reviews, accreditation efforts, quality improvement projects, and other performance improvement activities. Documentation could be, for example, meeting minutes, reports, presentations, memos, or other discussion records.	**2 examples**	**5 years**
2. Communication with the governing entity concerning the improvement of the health department's performance	**2. The health department must document communication with the governing entity on its performance improvement efforts as a result of performance improvement processes and/or activities.** The health department will select its documentation for this measure based on the model of governance in place for the health department. Documentation could be, for example, annual reports, department dashboards, program reviews, meeting minutes, reports, presentations, memos, or other record of discussion.	**2 examples**	**5 years**

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Public Health Emergency Preparedness and Response Capabilities

National Standards for State, Local, Tribal, and Territorial Public Health

October 2018

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Centers for Disease Control and Prevention
Center for Preparedness and Response

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Introduction

Public health systems play an integral role in preparing communities to respond to and recover from threats and emergencies. The public health consequences of disasters and emergencies initially affect local jurisdictions. During the initial response, the people and communities that are impacted must rely on local community resources. As a result, all state, local, tribal, and territorial emergency response stakeholders must be prepared to coordinate, cooperate, and collaborate with cross-sector partners and organizations at all governmental levels when emergencies occur, regardless of the type, scale, or severity.

While public health agencies are expected to take the lead when infectious disease outbreaks occur, jurisdictional public health agencies also must be prepared to coordinate with a diverse array of partners and stakeholders, including other government agencies to refine public health lead and support roles, responsibilities, and assignments when other technological, human-caused, or natural disasters occur.

In 2011, the Centers for Disease Control and Prevention (CDC) established the Public Health Preparedness Capabilities: National Standards for State and Local Planning, a set of 15 distinct, yet interrelated, capability standards designed to advance the emergency preparedness and response capacity of state and local public health systems. These standards pioneered a national capability-based framework that helped jurisdictional public health agencies structure emergency preparedness planning and further formalize their public health agency Emergency Support Function (ESF) #8 role(s) in partnership with emergency management agencies.

Each capability standard identifies priority resource elements that are relevant to both routine public health activities and essential public health services. This helps support an "everyday use" model in which applying the capability standards to improve day-to-day effectiveness builds a stronger foundation from which a jurisdictional public health agency can surge when an emergency incident occurs. Although jurisdictional public health agencies can demonstrate capability through exercises, planned events, and real incident responses, they also are encouraged to incorporate routine public health agency activities strategically into demonstration projects to test and evaluate their emergency preparedness and response capacity.

Public Health Emergency Preparedness Cooperative Agreement Program

In 1999, CDC competitively awarded approximately $40 million to 50 states and four major metropolitan health departments to support bioterrorism preparedness and response. The program, now administered by CDC's Center for Preparedness and Response, Division of State and Local Readiness (DSLR), evolved into the current Public Health Emergency Preparedness (PHEP) cooperative agreement.

Today, the PHEP program funds 62 cooperative agreement recipients: 50 states, four localities, and eight territories and freely associated states. Depending upon the organizational structure of the funded jurisdictional public health agency, directly funded PHEP recipients may share PHEP funding with local public health agencies, tribes, and native-serving organizations. This approach provides financial resources to help build public health emergency response capability both nationally and at state, local, tribal, and territorial government levels.

Since the initial publication of the preparedness capability standards in 2011, CDC has required that the 62 PHEP recipients develop and implement capability-based work plans and use their PHEP funding to build and sustain their public health preparedness and response capacity. However, use of the capability standards now extends well beyond informing jurisdictional public health agency cooperative agreement work plans. Today, the capability standards are a vital framework for jurisdictional public health agencies to organize and evaluate emergency responses and exercises, ensure the public health consequences of jurisdictional emergencies are a response priority, and promote collaboration by establishing a common language among preparedness professionals. Perhaps most importantly, the capability standards allow state, local, tribal, and territorial public health agencies to advance response strategies aligned with community needs, preferences, and resources without dictating or overprescribing "how" to specifically manage every jurisdictional response.

Operational Support for the National Preparedness System and the National Preparedness Goal

CDC's capability standards and PHEP cooperative agreement program provide operational support for the Federal Emergency Management's (FEMA) National Preparedness System to strengthen the security and resilience of the United States through systematic preparation for threats that pose the greatest risk to the nation's security. The National Preparedness System has six parts that include identifying and assessing risk, estimating capability requirements, building and sustaining capabilities, planning to deliver capabilities, validating capabilities, and reviewing and updating.

The National Preparedness System outlines an organized process for everyone in the whole community to advance their preparedness activities and achieve the National Preparedness Goal

> **"A secure and resilient nation with the capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk." (FEMA, 2015)**

The National Preparedness Goal describes a vision for preparedness nationwide and identifies 32 core capabilities necessary to achieve that vision across five mission areas: Prevention, Protection, Mitigation, Response, and Recovery. Although only one of the 32 core capabilities within the National Preparedness Goal specifically focuses on public health and medical support (Public Health, Healthcare, and Emergency Medical Services), many of the core capabilities relate to and contain public health and medical considerations that are necessary to successfully achieve a secure and resilient nation.

CDC's 2018 Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health include operational considerations that support the public health and medical components of the 32 core capabilities specified in the National Preparedness Goal. Jurisdictions should use these operational considerations to develop their public health agency response strategies in greater alignment with the jurisdictional public health agency ESF #8 role.

Capability Update Initiative

Since the publication of the capability standards in 2011, public health emergency preparedness and response capacity has continued to be tested at national, state, local, tribal, and territorial levels. Ongoing risks related to chemical, biological, radiological, nuclear, and explosive incidents as well as cyberattacks further underscore the importance of updating and modernizing jurisdictional all-hazards public health preparedness and response strategies to address emerging technologies and new 21st century threats through a continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action (in accordance with FEMA's National Preparedness System).

The PHEP program underwent an internal review in 2015 to identify opportunities to strengthen program tools, resources, and guidance. The review identified the need for CDC to implement several public health emergency preparedness improvement initiatives, including the Capabilities Update Initiative, the formal process CDC used for revising the Public Health Preparedness Capabilities: National Standards for State and Local Planning.

The purpose of the Capability Update Initiative was to update, clarify, and streamline capability content and enact changes that would best support state, local, tribal, and territorial public health emergency preparedness work without drastically altering the established 15-capability structure. Thus, the update process applied a similar approach to that used for the initial development of the 2011 capability standards. The process included individual work groups for each of the 15 capabilities along with four additional cross-cutting work groups to address at-risk individuals with access and functional needs, tribal populations, environmental health, and pandemic influenza.

Lessons learned from public health emergency responses, updates to public health preparedness science, revised guidance and resources, findings from internal reviews and assessments, subject matter expert feedback from the practice community, and input from allied agencies all contributed to capability updates. In addition, representatives from professional associations, including the Association of Public Health Laboratories (APHL), the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE), the National Association of County and City Health Officials (NACCHO), and the National Emergency Management Association (NEMA) were instrumental in helping to shape the updated capability content.

Summary of Capability Updates

The 2018 Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health recognizes the maturity and experience jurisdictional public health emergency preparedness and response programs have gained since 2011. As with the 2011 version, technical content is informed by applicable guidance, science, practice, and input from subject matter experts. Examples of revisions include the addition of public health mission-ready packaging and the importance of identifying jurisdictional public health agency lead or support roles based on incident characteristics. Other revisions include updates to public health informatics, vaccine administration, coordination of infectious disease response, chemical laboratory requirements, environmental health, disaster epidemiology, and additional considerations for protecting the safety of emergency responders and volunteers. Unlike the 2011 version, this 2018 update does not include programmatic performance measures. However, jurisdictional public health agencies are encouraged to use the updated content to foster their own evaluation strategies.

The original capability structure remains in place, and capability titles are consistent with 2011 except for Capability 8. Previously recognized as Medical Countermeasure Dispensing, the new title, Capability 8: Medical Countermeasure Dispensing and Administration, better recognizes that pharmaceutical countermeasures, such as vaccines, antidotes, and antitoxins, can also be "administered" rather than "dispensed" like pills.

Overarching changes include

- Revising, resequencing, and merging some capability functions
- Defining capability tasks
- Changing "planning" resource elements to "preparedness" resource elements
- Revising all preparedness, skills and training, and equipment and technology resource elements
- Moving all suggested resources (hyperlinks to resource documents) to the CDC website, the CDC Online Technical Resource and Assistance Center (On-TRAC), and other publicly available websites

Capability Structure

Domains and Tiers

The capability standards are organized into six domains and two tiers. Tier 1 capability standards form the foundation for public health emergency preparedness and response. Tier 2 capability standards are more cross-cutting, and their development relies upon having Tier 1 capability standards established in collaboration with external partners and stakeholders. Although jurisdictional public health agencies should consider prioritizing development of Tier 1 capabilities, jurisdictional risk assessment findings and other community factors also may influence jurisdictional prioritization of some Tier 2 capabilities. For example, based on risk assessment findings and depending on the public health agency's ESF #8 role, a jurisdiction also may need to prioritize development of volunteer management strategies to ensure staffing support for medical countermeasure dispensing and administration activities.

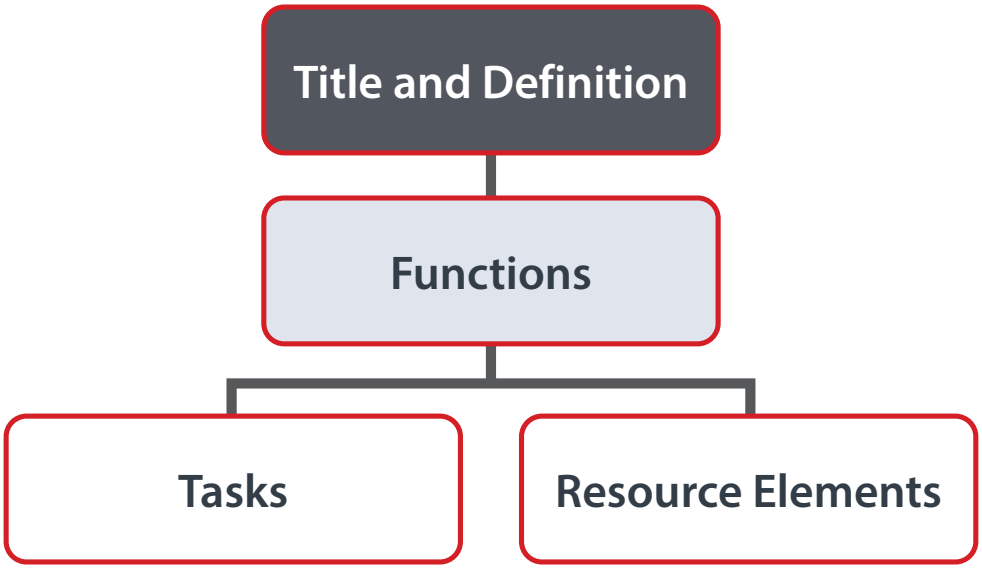
Domain	Capability and Tier
Community Resilience	Community Preparedness (Tier 1)
	Community Recovery (Tier 2)
Incident Management	Emergency Operations Coordination (Tier 1)
Information Management	Emergency Public Information and Warning (Tier 1)
	Information Sharing (Tier 1)
Countermeasures and Mitigation	Medical Countermeasure Dispensing and Administration (Tier 1)
	Medical Materiel Management and Distribution (Tier 1)
	Nonpharmaceutical Interventions (Tier 2)
	Responder Safety and Health (Tier 1)
Surge Management	Fatality Management (Tier 2)
	Mass Care (Tier 2)
	Medical Surge (Tier 2)
	Volunteer Management (Tier 2)
Biosurveillance	Public Health Laboratory Testing (Tier 1)
	Public Health Surveillance and Epidemiological Investigation (Tier 1)

Composition

Each capability standard comprises capability functions, and each capability function contains specific capability tasks that are supported by multiple capability resource elements.

- **Capability Title and Definition**—Description of the capability as it applies to state, local, tribal, and territorial public health agencies. Each definition includes a list of potential partners and stakeholders with which jurisdictions may consider working to achieve the capability
- **Capability Functions**—Critical segments of the capability that must occur to achieve the capability definition
- **Capability Tasks**—Action steps aligned to one or more capability functions. Capability tasks must be accomplished to complete a capability function
- **Capability Resource Elements**—Resources a jurisdiction should have or have access to in order to successfully perform capability tasks associated with capability functions. Resource elements are listed sequentially to align with corresponding tasks in each function. While not necessarily listed first, "**priority**" resource elements are potentially the most critical for completing capability tasks based on jurisdictional risk assessments and other forms of community input. The three categories of capability resource elements are
  - **Preparedness (P)**—Components to consider within existing operational plans, standard operating procedures, guidelines, documents, or other types of written agreements, such as contracts or memoranda of understanding (MOUs)
  - **Skills and Training (S/T)**—General baseline descriptions, competencies, and skills that personnel and teams should possess in order to achieve a capability
  - **Equipment and Technology (E/T)**—Infrastructure a jurisdiction should have or have access to with sufficient quantities or levels of effectiveness to achieve the intent of any related capability task

Capability Structure: Composition



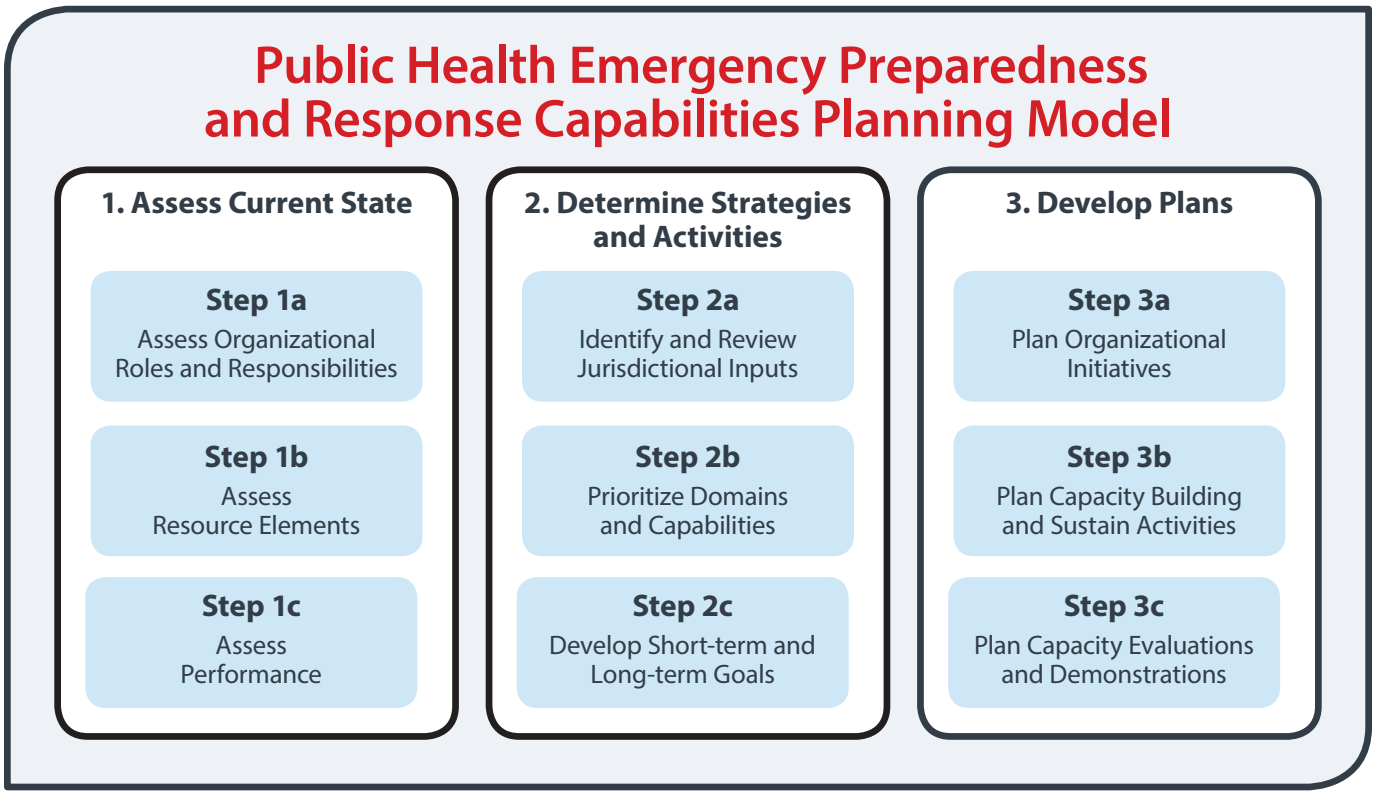
Using the Capability Standards for Strategic Planning

State, local, tribal, and territorial public health agencies exist within a landscape of diverse governance, organizational structures, legal authorities, partnerships, stakeholders, risks, demographics, and resources that influence jurisdiction-to-jurisdiction public health emergency preparedness priorities. The 2018 Public Health Emergency Preparedness and Response Capabilities: National Standards for State, Local, Tribal, and Territorial Public Health describes the components necessary to advance jurisdictional public health preparedness and response capacity.

The capability standards serve as a state, local, tribal, and territorial resource to assess, build, and sustain jurisdictional public health agency preparedness and response capacity by further defining the jurisdictional public health agency ESF #8 role while guiding program improvement initiatives to address preparedness and response planning gaps. Additionally, state, local, tribal, and territorial public health agencies must remain aware of new and emerging public health threats. From Capability 1: Community Preparedness to Capability 15: Volunteer Management, jurisdictional public health agencies must be adaptable when responding to public health threats and emergencies within the context of their communities and in alignment with incident characteristics.

Public Health Emergency Preparedness and Response Capabilities Planning Model

The following Public Health Emergency Preparedness and Response Planning Model updates the planning roadmap described in the 2011 Public Health Preparedness Capabilities: National Standards for State and Local Planning. It outlines a process jurisdictional public health agencies can follow to identify public health emergency preparedness and response program development priorities. Consistent with the U.S. Department of Homeland Security (DHS) Preparedness Cycle, the following diagram illustrates a three-phase approach to identify priorities and implement jurisdictional emergency preparedness planning and response initiatives.



Phase 1: Assess Current State

Step 1a: Assess Organizational Roles and Responsibilities

The first step in the assessment phase is to determine which organizational entities within the jurisdiction are responsible for each domain, capability standard, and applicable capability resource elements. Organizational entities may include allied state agencies, such as emergency management, partner organizations, other jurisdictional public health agencies, health care coalitions, community-based partners, and other jurisdictional stakeholders.

Step 1b: Assess Resource Elements

Each capability function includes a list of capability resource elements from three categories: preparedness, skills and training, and equipment and technology. To assess current capability, jurisdictions should review all resource elements (with emphasis on priority resource elements) and determine the extent of their availability within the jurisdiction. Public health agencies are not expected to be independently responsible for all capability resource elements, as the ability to achieve the capability standards relies heavily on partnerships.

Successfully attaining capability resource elements is defined as the ability to demonstrate that a jurisdictional public health agency either has (on hand or within existing plans and documents) or has access to (partner agency or organization has the jurisdictional authority or responsibility for the resource and evidence exists that agreements regarding roles and responsibilities are in place) the resource element. Strategies that address challenges and barriers for fully attaining capability resource elements should help inform jurisdictional planning, training, and exercise initiatives.

Step 1c: Assess Performance

The ability to achieve capability functions should be reviewed through jurisdictional demonstrations of performance and other types of evaluation. Examples of performance demonstrations may include using CDC-defined performance measures, measuring jurisdictional effectiveness when delivering "everyday" core public health agency mandates, as relevant, implementing jurisdictional training and exercise programs, and implementing formal after-action processes, including developing and completing corrective action plans.

Phase 2: Determine Strategies and Activities

Step 2a: Identify and Review Jurisdictional Inputs

In addition to assessing and reviewing capability resource elements, jurisdictions should review supplementary information sources to help identify jurisdictional needs and gaps. Supplementary information sources may include

- Existing data from jurisdictional hazard vulnerability analyses (jurisdictional risk assessment findings)
- Jurisdictional intelligence data, such as fusion center data or information obtained from intelligence reports or briefings
- Jurisdictional emergency management response plans, such as scenario-based plans
- Funding considerations, such as guidance or funding requirements from related federal preparedness programs
- Current public health strategic plans or strategic priorities
- Previous state and local accreditation or recognition efforts, such as Project Public Health Ready and Public Health Accreditation Board standards
- Jurisdictional results or action plans resulting from CDC operational readiness reviews
- After-action reports and corrective action plans

Step 2b: Prioritize Domains and Capabilities

The definitions described within the capability standards are broad. Jurisdictional public health agencies are not expected to simultaneously and completely address all identified issues, gaps, and needs across all capabilities in the short term. Instead, jurisdictions should periodically reprioritize the capability standards they pursue based on regularly updated jurisdictional inputs, including risk assessment findings.

Equally important, resource elements described within each capability function are not representative of all potential resource types or the quantities that may be required. Therefore, identifying the need for additional prioritization criteria when assessing individual capability resource elements is critical for public health agencies because resources that are not specifically stated in the capability standards may be necessary to achieve capability tasks.

Step 2c: Develop Short-term and Long-term Goals

For the purposes of this planning model, short-term goals are defined as one-year goals, and long-term goals are defined as two- to five-year goals. Jurisdictional public health agencies should review the various inputs described in step 2a, analyze their priorities based on the prioritization criteria described in step 2b, and determine a set of short-term and long-term capability development goals.

Goals for capability development should align with capability definitions, capability functions, capability tasks, and capability resource elements. For example, short-term goals may include building a particular set of tasks within a capability function by ensuring the presence of all priority resource elements, while a long-term goal would be to demonstrate performance and ultimately sustain all capability functions.

Phase 3: Develop Plans

Step 3a: Plan Organizational Initiatives

Jurisdictional public health agencies should establish concrete organizational initiatives and plan activities to achieve short- and long-term goals. For the purposes of this planning model, an assumption is made that activities specifically relate to individual capability domains, capability definitions, capability functions, capability tasks, and capability resource elements. However, in practice, jurisdictional public health agencies may group related activities to address multiple capability standards within any single project or program development initiative.

Step 3b: Plan Capacity Building and Sustain Activities

Generally, jurisdictional public health agencies build, sustain, or potentially scale back organizational initiatives based on the most recent assessment of needs, gaps, priorities, and goals. For build-and-sustain scenarios, jurisdictional public health agencies should pursue formal and informal partnerships where necessary based on the projected type(s) of support required. Guidance provided to local jurisdictional public health agencies should ideally describe development priorities for capability standards and capability functions. For scale-back scenarios, jurisdictional public health agencies should clearly identify specific conditions, such as strategic, budgetary, and risk assessments that influence the need to scale back efforts.

Jurisdictional public health agencies also should identify and prioritize technical assistance needed, from CDC or other sources, when developing the capability standards. Technical assistance needs may relate to the development of specific capability functions and capability resource elements, such as developing or modifying plans or processes, training personnel, or building or investing in new equipment and technology.

Step 3c: Plan Capacity Evaluations and Demonstrations

Demonstrating and evaluating strategies and activities are generally a later step in the capability development process. Jurisdictional public health agencies can demonstrate the capability standards by participating in various levels of exercises, planned events, and real incidents. CDC strongly encourages jurisdictional public health agencies to leverage routine public health activities, as applicable, to exercise and evaluate the capability standards. Exercises, events, or incidents should be documented and after-action reports and corrective action plans should be developed and implemented.

At-A-Glance: Capability Definitions, Functions, and Summary of Changes

Capability 1: Community Preparedness

Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders, the public health role in community preparedness is to

- Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness
- Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health
- Identify at-risk individuals with access and functional needs that may be disproportionately impacted by an incident or event
- Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals
- Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors
- Convene or participate with community partners to identify and implement additional ways to strengthen community resilience
- Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine risks to the health of the jurisdiction
- Function 2: Strengthen community partnerships to support public health preparedness
- Function 3: Coordinate with partners and share information through community social networks
- Function 4: Coordinate training and provide guidance to support community involvement with preparedness efforts

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Defines at-risk individuals as people with access and functional needs that may be disproportionately impacted by an incident or event, and provides parameters to identify those populations
- Highlights Americans with Disabilities Act (ADA) requirements in jurisdictional public health preparedness and response plans
- Accentuates the importance of community partnerships, including tribes and native-serving organizations in public health preparedness and response activities
- Promotes integration of community partners to support restoration of community networks and social connectedness to improve community resilience

Capability 2: Community Recovery

Definition: Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. Communities should consider collaborating with jurisdictional partners and stakeholders to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to at least a day-to-day level of functioning comparable to pre-incident levels and to improved levels, where possible.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify and monitor community recovery needs
- Function 2: Support recovery operations for public health and related systems for the community
- Function 3: Implement corrective actions to mitigate damage from future incidents

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Highlights the need to define the jurisdictional public health agency recovery lead and support role
- Supports the National Disaster Recovery Framework (NDRF)
- Promotes integration of community partners to support community recovery and restoration
- Emphasizes engagement of community partners to access hard-to-reach populations to ensure inclusive communications that meet the needs of the whole community

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to coordinate with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and the National Incident Management System (NIMS).

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct preliminary assessment to determine the need for activation of public health emergency operations
- Function 2: Activate public health emergency operations
- Function 3: Develop and maintain an incident response strategy
- Function 4: Manage and sustain the public health response
- Function 5: Demobilize and evaluate public health emergency operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Distinguishes the need to identify and clarify the jurisdictional ESF #8 response role based on incident type and characteristics
- Incorporates the National Health Security Strategy and Crisis Standards of Care for public health activation
- Emphasizes the importance of supporting development of mission-ready packages (MRPs) for mutual aid and understanding the Emergency Management Assistance Compact (EMAC)

Capability 4: Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Activate the emergency public information system
- Function 2: Determine the need for a Joint Information System
- Function 3: Establish and participate in information system operations
- Function 4: Establish avenues for public interaction and information exchange
- Function 5: Issue public information, alerts, warnings, and notifications

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Promotes the need to leverage social media platforms for issuing emergency public information and warnings
- Clarifies conditions for establishing a virtual Joint Information Center and Joint Information System
- Includes content to identify and reach populations at risk to be disproportionately impacted by incidents and those with limited access to public information messages

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with partner organizations and agencies to provide fatality management services. The public health agency role in fatality management activities may include supporting

- Recovery and preservation of remains
- Identification of the deceased
- Determination of cause and manner of death
- Release of remains to an authorized individual
- Provision of mental/behavioral health assistance for the grieving

The role also may include supporting activities for the identification, collection, documentation, retrieval, and transportation of human remains, personal effects, and evidence to the examination location or incident morgue.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine the public health agency role in fatality management
- Function 2: Identify and facilitate access to public health resources to support fatality management operations
- Function 3: Assist in the collection and dissemination of antemortem data
- Function 4: Support the provision of survivor mental/behavioral health services
- Function 5: Support fatality processing and storage operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Clarifies importance of identifying the public health agency role in fatality management and describes potential fatality management lead, advisory, and support roles
- Aligns the fatality management definition to the existing federal definition as recommended by the U.S. Department of Health and Human Services (HHS), Disaster Mortuary Operational Response Team (DMORT)
- Updates resources to improve coordination, accuracy, and timeliness of electronic mortality reporting

Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to all levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify stakeholders that should be incorporated into information flow and define information sharing needs
- Function 2: Identify and develop guidance, standards, and systems for information exchange
- Function 3: Exchange information to determine a common operating picture

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Emphasizes the need to implement data security and cybersecurity
- Emphasizes the need to decrease reporting time and increase collaboration by expanding use of electronic information systems, such as electronic death registration (EDR), electronic laboratory reporting (ELR), and syndromic surveillance systems

Capability 7: Mass Care

Definition: Mass care is the ability of public health agencies to coordinate with and support partner agencies to address, within a congregate location (excluding shelter-in-place locations), the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident. This capability includes coordinating ongoing surveillance and public health assessments to ensure that health needs continue to be met as the incident evolves.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine public health role in mass care operations
- Function 2: Determine mass care health needs of the impacted population
- Function 3: Coordinate public health, health care, and mental/behavioral health services
- Function 4: Monitor mass care population health

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates content for accommodating individuals with access and functional needs within general population shelters
- Includes considerations for registration of individuals requiring decontamination or medical tracking in the event of an environmental health incident
- Coordinated content with the HHS Assistant Secretary for Preparedness and Response's (ASPR) Health Care Preparedness and Response Capabilities

Capability 8: Medical Countermeasure Dispensing and Administration

Definition: Medical countermeasure dispensing and administration is the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident, according to public health guidelines. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Determine medical countermeasure dispensing/administration strategies
- Function 2: Receive medical countermeasures to be dispensed/administered
- Function 3: Activate medical countermeasure dispensing/administration operations
- Function 4: Dispense/administer medical countermeasures to targeted population(s)
- Function 5: Report adverse events

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Revises the Capability 8 title, definition, and content to account for both the dispensing and the administration of medical countermeasures, such as vaccines, antidotes, and antitoxins
- Adds content and resources to account for potential radiological or nuclear exposure
- Broadens the network of dispensing and administration sites to include pharmacies and other locations

Capability 9: Medical Materiel Management and Distribution

Definition: Medical materiel management and distribution is the ability to acquire, manage, transport, and track medical materiel during a public health incident or event and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Direct and activate medical materiel management and distribution
- Function 2: Acquire medical materiel from national stockpiles or other supply sources
- Function 3: Distribute medical materiel
- Function 4: Monitor medical materiel inventories and medical materiel distribution operations
- Function 5: Recover medical materiel and demobilize distribution operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Broadens the cold chain management guidance to include all aspects of storage and handling
- Expands recovery activities to incorporate proper handling and disposal of infectious, hazardous, or contaminated materiel and waste
- Accounts for security and inventory management tasks that occur throughout the entire distribution process

Capability 10: Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services, including disease surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Assess the nature and scope of the incident
- Function 2: Support activation of medical surge
- Function 3: Support jurisdictional medical surge operations
- Function 4: Support demobilization of medical surge operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Emphasizes the need to define public health agency lead and support roles within medical surge operations
- Eliminates use of the term "HAvBED" because the term is no longer promoted by the Hospital Preparedness Program (HPP) and focuses instead on "situational awareness" and "health care systems tracking" as an overarching theme
- Emphasizes the need to identify and clarify the jurisdictional ESF #8 response role in medical surge operations based on jurisdictional role and incident characteristics

Capability 11: Nonpharmaceutical Interventions

Definition: Nonpharmaceutical interventions are actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. This capability focuses on communities, community partners, and stakeholders recommending and implementing nonpharmaceutical interventions in response to the needs of an incident, event, or threat. Nonpharmaceutical interventions may include

- Isolation
- Quarantine
- Restrictions on movement and travel advisories or warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Engage partners and identify factors that impact nonpharmaceutical interventions
- Function 2: Determine nonpharmaceutical interventions
- Function 3: Implement nonpharmaceutical interventions
- Function 4: Monitor nonpharmaceutical interventions

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Focuses on collaboration by expanding suggested partners for implementing nonpharmaceutical interventions
- Supports establishment of community reception center processes to enhance ability to respond to radiological and nuclear threats
- Highlights management of mass gatherings (delay and cancel) based on all-hazards scenarios

Capability 12: Public Health Laboratory Testing

Definition: Public health laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens and food, water, and other environmental samples. This capability supports passive and active surveillance when preparing for, responding to, and recovering from biological, chemical, and radiological (if a Radiological Laboratory Response Network is established) public health threats and emergencies.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct laboratory testing and report results
- Function 2: Enhance laboratory communications and coordination
- Function 3: Support training and outreach

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Updates Laboratory Response Network (LRN) requirements
- Incorporates LRN-chemical requirements
- Prioritizes cooperation, coordination, and information sharing with LRN laboratories, other public laboratories, and jurisdictional sentinel laboratories

Capability 13: Public Health Surveillance and Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes. It also includes the ability to expand these systems and processes in response to incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Conduct or support public health surveillance
- Function 2: Conduct public health and epidemiological investigations

- Function 3: Recommend, monitor, and analyze mitigation actions
- Function 4: Improve public health surveillance and epidemiological investigation systems

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Strengthens surveillance systems for persons in isolation or quarantine and persons placed under monitoring and movement protocols
- Emphasizes syndromic surveillance and data collection to improve situational awareness and responsiveness to hazardous events and disease outbreaks, for example, participation in CDC's National Syndromic Surveillance Program BioSense Platform

Capability 14: Responder Safety and Health

Definition: Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Identify responder safety and health risks
- Function 2: Identify and support risk-specific responder safety and health training
- Function 3: Monitor responder safety and health during and after incident response

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates the need to securely manage responder data
- Improves responder on-site management, tracking, in-processing, and out-processing
- Reprioritizes hierarchy of control and promotes the alignment of responder safety and health control measures, for example, personal protective equipment (PPE), with jurisdictional risk assessment findings

Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post-deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- Function 1: Recruit, coordinate, and train volunteers
- Function 2: Notify, organize, assemble, and deploy volunteers
- Function 3: Conduct or support volunteer safety and health monitoring and surveillance
- Function 4: Demobilize volunteers

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Addresses the need to monitor volunteer safety, risks, and actions during and after an incident
- Strengthens and clarifies volunteer eligibility considerations, such as medical, physical, and emotional health, during the volunteer selection process
- Promotes use of Emergency Responder Health Monitoring and Surveillance™ (ERHMS™)

Capability 1: Community Preparedness

Definition: Community preparedness is the ability of communities to prepare for, withstand, and recover from public health incidents in both the short and long term. Through engagement and coordination with a cross-section of state, local, tribal, and territorial partners and stakeholders, the public health role in community preparedness is to

- Support the development of public health, health care, human services, mental/behavioral health, and environmental health systems that support community preparedness
- Participate in awareness training on how to prevent, respond to, and recover from incidents that adversely affect public health
- Identify at-risk individuals with access and functional needs that may be disproportionately impacted by an incident or event
- Promote awareness of and access to public health, health care, human services, mental/behavioral health, and environmental health resources that help protect the community's health and address the access and functional needs of at-risk individuals
- Engage in preparedness activities that address the access and functional needs of the whole community as well as cultural, socioeconomic, and demographic factors
- Convene or participate with community partners to identify and implement additional ways to strengthen community resilience
- Plan to address the health needs of populations that have been displaced because of incidents that have occurred in their own or distant communities, such as after a radiological or nuclear incident or natural disaster

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Determine risks to the health of the jurisdiction
- **Function 2:** Strengthen community partnerships to support public health preparedness
- **Function 3:** Coordinate with partners and share information through community social networks
- **Function 4:** Coordinate training and provide guidance to support community involvement with preparedness efforts

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Defines at-risk individuals as people with access and functional needs that may be disproportionately impacted by an incident or event, and provides parameters to identify those populations
- Highlights Americans with Disabilities Act (ADA) requirements in jurisdictional public health preparedness and response plans
- Accentuates the importance of community partnerships, including tribes and native-serving organizations in public health preparedness and response activities
- Promotes integration of community partners to support restoration of community networks and social connectedness to improve community resilience

Return to Crosswalk

For the purposes of Capability 1, partners and stakeholders may include the following: all parts of the whole community such as individuals, businesses, nonprofits, community and faith-based organizations, and all levels of government.

Specific partners and stakeholders may include

- animal services and agencies
- childcare organizations
- chronic disease programs
- communicable disease programs
- community coalitions
- emergency management agencies
- emergency medical services (EMS)
- environmental health agencies
- fire and rescue departments
- groups representing and serving populations with access and functional needs
- health care coalitions
- health care organizations (private and community-based)
- health care systems and providers
- health care associated infection control programs
- housing and sheltering authorities
- human services providers
- immunization programs
- jurisdictional strategic advisory councils
- law enforcement
- media organizations
- mental/behavioral health providers
- public health preparedness programs
- schools and education agencies
- social services
- state office of aging or its equivalent
- surveillance programs
- volunteer organizations

Function 1: Determine risks to the health of the jurisdiction

Function Definition: Identify potential jurisdictional public health, health care, mental/behavioral health, and environmental health hazards, vulnerabilities, and risks, and assess the human impact because of interruption of public health, health care, human services, mental/behavioral health, and environmental health services and supporting infrastructure.

Tasks

Task 1: Conduct a public health jurisdictional risk assessment. Identify and prioritize jurisdictional risks, risk-reduction strategies, and risk-mitigation efforts in coordination with community partners and stakeholders.

Task 2: Support jurisdictional partners and stakeholders to identify services to reduce and mitigate identified jurisdictional public health risks. Support community partners and stakeholders to identify public health, health care, human services, mental/behavioral health, and environmental health services capable of supporting public health risk-reduction strategies and mitigation efforts.

Preparedness Resource Elements

P1: (Priority) Procedures in place to identify at-risk populations that may be disproportionately impacted by incidents or events. At-risk populations include individuals with access and functional needs, such as needs related to communication, maintaining health, independence, support, safety, self-determination, and transportation (CMIST), as defined in the CMIST framework. At-risk populations may include individuals who

- Are at higher risk of severe complications from infectious diseases, such as pandemic influenza, for example, older adults, pregnant women, children, and people with pre-existing chronic medical conditions, such as diabetes or heart disease
- Have limitations that interfere with the receipt of and response to information, such as individuals who may not be able to hear, see, understand, or act on safety information
- Rely on personal care assistance to manage or maintain health
- Function independently if they have durable medical equipment or other assistive devices, service animals, or personal assistance service providers
- Find it difficult to cope in a new environment, such as those with autism, dementia, or intense anxiety
- Have transportation needs, including those who use public transit or accessible vehicles, such as lift-equipped or vehicles suitable for transporting individuals who use oxygen tanks

P2: (Priority) Jurisdictional risk assessments, which may include

- Identification of potential hazards, such as geographic and physical hazards, vulnerabilities, risks related to population characteristics, such as population density and demographics, and other risks in the community with the potential to adversely impact public health and related health care, human services, mental/behavioral health, and environmental health systems
- A definition of risk, including a risk formula
- The relation between identified risks to human impact and the interruption of public health, health care, human, mental/behavioral health, and environmental health services, noting that certain responses may affect basic functions of society, including physical damage to infrastructure or a reduction in the critical workforce
- Estimate of plausibility or probability of risks and hazards for the jurisdiction, such as the likelihood of natural disasters based on historical precedence
- Size and characteristics of the jurisdiction's population
  - Identification or location of populations with access and functional needs
  - Identification of populations with limited language proficiency (language isolation) and limited access to communication channels to receive timely and effective public health information
  - Information on vulnerabilities based on socioeconomic status, education, culture, and other factors
  - Locations or mapping of populations using information sources, including geographic information systems (GIS), the Agency for Toxic Substances and Disease Registry (ATSDR) Social Vulnerability Index, HHS emPOWER data, and other sources
- Data on the size and type of animal populations within the jurisdiction

Jurisdictional risk assessments may be conducted using information, which may include

- Consultation with subject matter experts from jurisdictional partners and stakeholders
- Data that help prioritize jurisdictional hazards and public health vulnerabilities, including historical data from emergency management risk assessment(s), public health programs, relevant scenarios or models, community engagements, GIS, and other supplementary sources
- Identification of factors that influence community resilience
- Estimated impact on public health, environmental health, and health care system functioning, for example, the potential loss or disruption of essential services, such as water, sanitation, vector control, electricity, or other utilities, or the interruption of public health, human services, environmental health, or health care infrastructure and services

P3: Written agreements, such as contracts or memoranda of understanding (MOUs), with applicable stakeholders within the jurisdiction or in neighboring jurisdictions to provide access to health care, human services, mental/behavioral health, and environmental health services, as necessary.

Skills and Training Resource Elements

S/T1: Personnel trained to locate or map at-risk populations using GIS, social vulnerability indexes, and other community assets, such as partnerships with human services and other safety net services to integrate aggregate data or client and consumer lists.

S/T2: Personnel familiar with methods and principles for developing and administering jurisdictional risk assessments.

S/T3: Personnel trained in the Federal Emergency Management Agency (FEMA) Emergency Management Institute course IS-305: Environmental Health Training in Emergency Response (EHTER) Awareness and other EHTER training opportunities.

Equipment and Technology Resource Elements

E/T1: Public health agency may coordinate with other governmental agencies for example, emergency management agencies or academic institutions, such as schools of public health or geography departments, as needed, for access to GIS systems.

Function 2: Strengthen community partnerships to support public health preparedness

Function Definition: Identify and engage public and private community partners to

- Assist with informing jurisdictional risk assessments, mitigating identified health hazards, and controlling risks
- Integrate all-hazards emergency plans with identified community roles and responsibilities related to the provision of public health, health care, human services, mental/behavioral health, and environmental health services
- Define Emergency Support Function (ESF) #8 public health roles at the state, local, tribal, or territorial level
- Implement additional activities to strengthen community resilience

Tasks

Task 1: Engage community partners and other stakeholders to support risk-mitigation. Define and implement strategies for ongoing collaboration with community partners and stakeholders capable of providing services to mitigate pre-identified general and incident-specific public health hazards and controlling risks for targeted populations.

Task 2: Coordinate the delivery of essential public health services. Partner with organizations responsible for essential health care and human services to ensure those services are provided as early as possible during the response, recovery, and return of the public health system after the incident or event.

Task 3: Incorporate partner feedback to continuously improve emergency operations plans. Establish and implement continuous quality improvement methods, including formal after-action processes, to collect and incorporate feedback from community and faith-based partners into emergency operations plans.

Task 4: Engage trusted community spokespersons to deliver public health messages. Collaborate with community partners and stakeholders to develop, test, and disseminate timely public health messaging to targeted populations through trusted representatives or spokespersons.

Preparedness Resource Elements

P1: (Priority) Procedures in place to coordinate relationships with community partners and stakeholders.

P2: (Priority) Procedures in place to register health care personnel, such as physicians, nurses, and allied health professionals from community, faith-based, and professional organizations in the Medical Reserve Corps (MRC) or state Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) programs to support health services.

(See Capability 15: Volunteer Management)

P3: Procedures in place to integrate community and faith-based partner roles and responsibilities for each stage of a public health incident or event.

P4: Procedures and venues in place to discuss and provide guidance on public health hazard policies and plans of action with community partners and other stakeholders. Venues may include town hall meetings, community gatherings, conferences, and other social engagements.

P5: (Priority) Stand-alone plans, annexes, or other documentation, developed with input from jurisdictional partners, to indicate how the public health agency will assist with activities, which may include

- Continuity of operations for public health, health care, human, mental/behavioral health, and environmental health services within the community, including vaccination and dispensing services using a variety of provider types and settings, such as pharmacies, doctors' offices, school-located vaccination clinics, occupational health or worksite clinics, point-of-dispensing sites, and other traditional and non-traditional locations, during and after an incident. Particular attention should be placed on accessibility of health and human services for at-risk individuals with access and functional needs who may be disproportionately impacted by a public health incident or event, including displaced populations
- Support to address concerns and needs of populations not directly impacted by a particular incident, but concerned about the possibility of adverse health effects. Support services may include
  - Health care
  - Relocation services
  - Sheltering
  - Caregiving
  - Family reunification
  - Other standard services
- Collaboration with community partners to assess and plan for the access and functional needs of at-risk individuals who may be disproportionately impacted by an incident

- Childcare coordination with education and childcare sectors as well as systems that routinely serve children, such as child welfare, foster care, childcare or Head Start, runaway and youth homelessness, and juvenile justice agencies
- Support for animal services and pet care, as applicable
- Psychological first aid and other relevant mental/behavioral health services
- Communication services, which may include interpreter services for populations with limited English proficiency, methods to reach populations with limited access to public health messaging, or methods to alert and communicate with people with hearing, vision, speech, cognitive, and other disabilities

P6: Procedures in place to identify jurisdictional public health agency ESF #8 lead or support roles and functions based on incident characteristics, legal authorities, and existing mandates.

(See Capability 3: Emergency Operations Coordination)

Skills and Training Resource Elements

S/T1: Personnel able to demonstrate the skills and competencies in Domain 3: Plan for and Improve Practice, within the Public Health Preparedness and Response Core Competency Model.

Function 3: Coordinate with partners and share information through community social networks

Function Definition: Engage with community organizations to foster social connections that ensure the availability and community awareness of public health, health care, human, mental/behavioral health, and environmental health services in response to an incident.

Tasks

Task 1: Engage with community partners and stakeholders to coordinate preparedness efforts. Coordinate with community partners to ensure they understand how to access and connect their stakeholders and populations they serve to public health resources during an incident.

Task 2: Provide opportunities for community health services to participate in jurisdictional public health emergency preparedness activities. Engage public health, health care, human services, mental/behavioral health, and environmental health organizations that provide essential health services to the community in the development, implementation, and review of jurisdictional public health emergency preparedness efforts.

Task 3: Leverage community networks to disseminate information during an incident. Use local businesses, community and faith-based organizations, radio and other broadcast media, social media, text messaging, and other channels, as applicable, in communication networks to disseminate timely, relevant, accessible, and culturally appropriate information throughout the whole community during an incident.

Preparedness Resource Elements

P1: Procedures and problem-solving strategies in place to ensure access to public health, health care, human, mental/behavioral health, and environmental health services and to identify and engage community partners and stakeholders to support the restoration of community networks and social connectedness (social cohesion).

P2: Procedures in place to define and continuously update community-specific, information-sharing needs within jurisdictions.

(See Capability 6: Information Sharing)

P3: Culturally and socially appropriate health services needed to support identified jurisdictional risks and associated hazards.

(See Capability 4: Emergency Public Information and Warning)

Function 4: Coordinate training and provide guidance to support community involvement with preparedness efforts

Function Definition: Provide public health preparedness and response training and guidance to community partners and other stakeholders in order to address risks including, but not limited to, those identified in the jurisdictional risk assessment.

Tasks

Task 1: Leverage existing disaster preparedness and response trainings and educational programs to build community resilience. Coordinate with community partners and stakeholders to implement existing training and educational programs that incorporate community-based approaches to preparedness and recovery.

Task 2: Promote training and guidance for community partners. Promote training initiatives for community partners and other stakeholders within public health, health care, human services, mental/behavioral health, and environmental health sectors.

Task 3: Provide guidance to groups representing at-risk populations. Promote training and education of community partners and stakeholders to support preparedness and recovery for populations that may be disproportionately impacted by an incident or event based on the jurisdiction's identified risks and increase awareness of and access to services that may be needed during and after the incident.

Preparedness Resource Elements

P1: (Priority) Procedures in place to inform child service providers, such as schools, pediatricians, and children's mental health of and encourage their participation in jurisdictional strategies for addressing children's needs. Procedures may include

- Approaches to support family reunification
- Care for children whose caregivers are deceased, ill, injured, missing, quarantined, or otherwise incapacitated for lengthy periods of time
- Approaches to help children with access and functional needs
- Approaches to strengthen parents' and caregivers' coping skills
- Support for positive mental/behavioral health outcomes in children affected by the incident
- Approaches to help children and adults understand the incident

P2: Procedures in place to provide guidance and training programs, such as FEMA, CDC, and jurisdictional training to partners serving populations that rely on support services, such as HIV/AIDS treatment, substance abuse treatment, and dialysis that may not be accessible during or after an incident.

P3: (Priority) Procedures in place to build and sustain volunteer opportunities for community residents to support jurisdictional emergency responders and community safety efforts year-round, such as coordination with the MRC.

(See Capability 15: Volunteer Management)

Skills and Training Resource Elements

S/T1: Emergency responders, citizen volunteers, and other community residents trained in standardized and competency-based disaster education and training programs, such as the National Disaster Life Support Program and National and State Voluntary Organizations Active in Disaster (VOAD) planning documents.

S/T2 MRC volunteers and procedures to ensure coordination with existing community emergency response teams (CERTs) or Citizen Corps or support for the state ESAR-VHP program.

(See Capability 15: Volunteer Management)

Return to Crosswalk

Capability 2: Community Recovery

Definition: Community recovery is the ability of communities to identify critical assets, facilities, and other services within public health, emergency management, health care, human services, mental/behavioral health, and environmental health sectors that can guide and prioritize recovery operations. Communities should consider collaborating with jurisdictional partners and stakeholders to plan, advocate, facilitate, monitor, and implement the restoration of public health, health care, human services, mental/behavioral health, and environmental health sectors to at least a day-to-day level of functioning comparable to pre-incident levels and to improved levels, where possible.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Identify and monitor community recovery needs
- **Function 2:** Support recovery operations for public health and related systems for the community
- **Function 3:** Implement corrective actions to mitigate damage from future incidents

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Highlights the need to define the jurisdictional public health agency recovery lead and support role
- Supports the National Disaster Recovery Framework (NDRF)
- Promotes integration of community partners to support community recovery and restoration
- Emphasizes engagement of community partners to access hard-to-reach populations to ensure inclusive communications that meet the needs of the whole community

For the purposes of Capability 2, partners and stakeholders may include the following: all parts of the whole community, such as individuals, businesses, nonprofits, community and faith-based organizations, and all levels of government.

Specific partners and stakeholders may include

- animal services and agencies
- childcare organizations
- chronic disease programs
- communicable disease programs
- community coalitions
- emergency management agencies
- emergency medical services (EMS)
- environmental health agencies
- fire and rescue departments
- groups representing and serving populations with access and functional needs
- health care coalitions
- health care organizations (private and community-based)
- health care systems and providers
- health care associated infection control programs
- housing and sheltering authorities
- human services providers
- immunization programs
- jurisdictional strategic advisory councils
- law enforcement
- media organizations
- mental/behavioral health providers
- public health preparedness programs
- schools and education agencies
- social services
- state office of aging or its equivalent
- surveillance programs
- volunteer organizations

Return to Crosswalk

Function 1: Identify and monitor community recovery needs

Function Definition: Assess the impact of an incident on the public health system in collaboration with jurisdictional partners and stakeholders to prioritize public health, emergency management, health care, mental/behavioral health, environmental health, and applicable human services recovery needs.

Tasks

Task 1: Identify jurisdictional community recovery priorities. Collaborate with jurisdictional partners and stakeholders to identify and document jurisdictional community recovery issues and priorities based on the impact of an incident on the population and critical assets, facilities, and other services within the public health, emergency management, health care, mental/behavioral health, and environmental health sectors.

Task 2: Identify the jurisdictional public health agency role in community recovery. In collaboration with the jurisdictional emergency management agency and organizations representing jurisdictional Emergency Support Functions (ESFs) and Recovery Support Functions (RSFs), identify the jurisdictional public health agency lead or support roles for community recovery.

Task 3: Identify recovery services to be provided by the jurisdictional public health agency, partners, and stakeholders. Determine public health agency, partners, and stakeholders services that can be provided for short- and long-term recovery operations, including previously identified services and new services, as appropriate, to address emerging community recovery needs.

Task 4: Solicit community input from jurisdictional partners and stakeholders. Request community input from jurisdictional partners and stakeholders regarding public health service recovery needs before and after the incident to understand recovery needs, issues, barriers, and trends.

Preparedness Resource Elements

P1: (Priority) Procedures in place for collaborating with jurisdictional partners and stakeholders to determine community recovery priorities and to define jurisdictional public health agency role(s) in community recovery. Considerations for determining community recovery priorities and the jurisdictional public health agency role(s) may include

- Recovery needs based on the scope of the incident and available assets, such as funding, volunteers, and other resources for responding to identified hazards
- Public health agency organizational structure, such as whether environmental health or mental/behavioral health services are separate agencies, legal authorities, and existing jurisdictional public health agency mandates
- Short- and long-term public health service delivery priorities and recovery goals
- Periodic assessment of incident impact information to characterize the size or extent of the incident and the sectors and populations impacted
- Review, assessment, and organization of recovery needs to facilitate timely and efficient reporting to federal, regional, state, local, tribal, and territorial emergency management agencies to support situational awareness and resource requests

Return to Crosswalk

P2: (Priority) Procedures in place for how the jurisdictional public health agency and jurisdictional partners and stakeholders will assess, conduct, monitor, document, and follow up with public health, emergency management, health care, mental/behavioral and environmental health, and human services needs to support jurisdictional recovery efforts. Procedures may include conducting community assessments or mission scoping assessments (MSAs) performed by federal and state RSF personnel.

(See Capability 1: Community Preparedness, Capability 7: Mass Care, Capability 10: Medical Surge, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P3: Predefined procedures, egress (exit) strategies, staging locations, and community reception centers for addressing hazards if they persist in the community or environment over time.

P4: Procedures in place to identify state and applicable jurisdictional legal authorities that permit non-jurisdictional clinicians to be credentialed to work in emergency situations.

(See Capability 1: Community Preparedness, Capability 7: Mass Care, Capability 8: Medical Countermeasure Dispensing and Administration, and Capability 10: Medical Surge)

P5: Documentation of identified sectors and partners that can support short-, intermediate-, and long-term community recovery efforts, including services to address the access and functional needs of identified at-risk populations who may be disproportionately impacted by a public health incident or event.

P6: Regularly scheduled community sector forums or local emergency planning committee meetings for representatives from different community sectors to collaborate. Activities may include

- Developing continuity of operations (COOP) plans
- Coordinating overall jurisdictional public health continuity of operations and community recovery roles
- Establishing and maintaining organizational relationships
- Sharing promising practices or approaches to recovery from similar incidents
- Learning about jurisdictional response and recovery processes and policies
- Exchanging information to identify available recovery support services by sector, such as shelter, day care, spiritual guidance, animal care, food, medication support, and transportation

(See Capability 1: Community Preparedness)

Function 2: Support recovery operations for public health and related systems for the community

Function Definition: Facilitate collaboration among jurisdictional partners and stakeholders to build a network of support services to reduce adverse public health consequences resulting from the incident, and develop plans to expedite recovery operations as appropriate based on the jurisdictional public health agency lead or support roles.

Tasks

Task 1: Coordinate with jurisdictional partners and stakeholders to develop recovery solutions. Identify courses of action to address persistent or emergent recovery issues and coordinate among health care, emergency management, education, nonprofit, and social services partners to design solutions, plans, and services based on jurisdictional public health agency lead or support roles.

Return to Crosswalk

Task 2: Educate the community about public health services. Coordinate with community partners and stakeholders from within and outside the jurisdiction to educate the community regarding recommended public health services through unified messaging.

Task 3: Notify the community of jurisdictional public health agency recovery plans. In coordination with other jurisdictional agencies, notify the community of jurisdictional public health agency recovery plans that support the restoration of public health, emergency management, health care, mental/behavioral health, and environmental health services during and after the acute phase of the incident.

Task 4: Notify the community of available public health services. In coordination with jurisdictional partners and stakeholders, communicate recovery services available to the community, with attention to the access and functional needs of populations that may be disproportionately impacted.

Task 5: Inform the community of disaster case management or community case management services. In collaboration with jurisdictional partners and stakeholders, notify the community of available disaster case management or community case management services for impacted community members.

Task 6: Coordinate with jurisdictional emergency management agencies to support mutual aid agreements with neighboring jurisdictions to provide recovery services. Partner with jurisdictional emergency management agencies when developing intra- and inter-state public health mutual aid and resource sharing agreements with neighboring jurisdictions for the provision of community recovery support resources and services.

Preparedness Resource Elements

P1: (Priority) Integrated recovery coordination plan that accounts for the jurisdictional public health agency lead or support roles. The integrated recovery coordination plan should include

- Major public health recovery priorities
- Short-, intermediate-, and long-term recovery issues based on known hazards
- Intended actions to address identified public health recovery priorities
- Expected or intended actions to support a federally-led recovery support strategy

P2: Procedures in place to routinely collect and share response and recovery information, including information about community recovery priorities resulting from cross-jurisdictional and inter-state coordination with organizations providing outreach to impacted populations. Procedures should specify who is responsible for developing messages and identifying audiences, such as community partners, the community at large, and populations disproportionately impacted by the incident.

(See Capability 4: Emergency Public Information and Warning, Capability 6: Information Sharing, Capability 8: Medical Countermeasure Dispensing and Administration, and Capability 11: Nonpharmaceutical Interventions)

P3: Procedures in place to support regular monitoring, surveillance, and reporting to track health, social services, and case management-related recovery over the long term, depending on the incident.

(See Capability 4: Emergency Public Information and Warning, Capability 6: Information Sharing, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

Return to Crosswalk

P4: (Priority) Procedures in place within a stand-alone public health COOP plan or as a component of another plan to support community recovery. Procedures may include

- Definitions, identification, and prioritization of essential services needed to sustain public health agency mission and operations
- Procedures to sustain essential services regardless of the nature of the incident (all-hazards planning)
- Positions, skills, and personnel needed to continue essential services and functions (human capital management)
- Identification of public health agency and personnel roles and responsibilities in support of ESF #8—Public Health and Medical Services
- Scalable workforce reduction
- Limited access to facilities because of issues, such as structural safety or security concerns
- Broad-based implementation of social distancing policies
- Identification of agency vital records, such as legal documents, payroll, personnel assignments that must be preserved to support essential functions or for other reasons
- Alternate and virtual worksites
- Devolution of uninterruptible services for scaled down operations
- Reconstitution of uninterruptible services
- Cost of additional services to augment recovery

P5: Predefined statements (message templates) that address expected questions and concerns related to the incident. Public health spokespersons should consider strategies that may include

- Collaborating with jurisdictional partners and stakeholders to develop unified, timely, and consistent messaging across agencies
- Using message maps when interacting with jurisdictional media and community organizations
- Developing tailored messages, such as fact sheets to disseminate information to the public and responders to help amplify support for disaster survivors

(See Capability 1: Community Preparedness, Capability 3: Emergency Operations Coordination, and Capability 4: Emergency Public Information and Warning)

P6: Recovery strategies that guide the timely provision of public health, health care, and mental/behavioral health care beyond initial life-sustaining care. Strategies based on the jurisdictional public health agency role may include

- Accessible, safe, and functional facilities to provide public health services, including restoration of facilities or designation of new facilities, as necessary
- Short- and long-term programs and services for disaster survivors, responders, and the public
- Programs and interventions for managing stress, grief, fear, panic, anxiety, and other medical, human services, and mental/behavioral health issues for disaster survivors, responders, and the public

(See Capability 1: Community Preparedness and Capability 14: Responder Safety and Health)

P7: Procedures in place to coordinate health and related community services for physical injury, illness, mental/behavioral trauma, or environmental exposures sustained as a result of the incident.

(See Capability 10: Medical Surge)

Return to Crosswalk

P8: Procedures in place to support environmental health operations.

(See Capability 11: Nonpharmaceutical Interventions, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 15: Volunteer Management)

Skills and Training Resource Elements

S/T1: Volunteers from the Medical Reserve Corps (MRC) and other sources, such as Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) trained in expected roles and responsibilities for community recovery activities. Training programs may incorporate mental health or psychological first aid to address immediate post-disaster behavioral health needs.

(See Capability 15: Volunteer Management)

S/T2: Environmental health personnel trained in mitigation of public health hazards related to disaster debris removal, hazardous waste, radiation, sanitation, and vector control.

(See Capability 14: Responder Safety and Health)

Function 3: Implement corrective actions to mitigate damage from future incidents

Function Definition: Incorporate improvement observations from past incidents to inform actions needed to restore the public health, health care systems, mental/behavioral and environmental health, and human services sectors to at least a day-to-day level of functioning comparable to pre-incident and to improved levels, where possible. Document actions within written after-action reports (AARs) and improvement plans (IPs) and implement corrective actions based on jurisdictional public health lead or support roles.

Tasks

Task 1: Conduct post-incident assessment and planning for AARs and IPs. In collaboration with jurisdictional partners and stakeholders, conduct post-incident assessment and planning as part of the after-action process for short- and long-term recovery efforts.

Task 2: Facilitate collaboration between government and the community to develop corrective action plans. Facilitate and advocate for collaboration among government agencies and community partners to support the completion of agency-specific corrective actions.

Task 3: Collect community feedback for corrective actions. Collaborate with sector leaders to facilitate collection of community feedback to inform and identify corrective actions.

Task 4: Implement corrective actions into recovery plans and operations. Implement corrective actions that are within the scope or control of the jurisdictional public health agency for short- and long-term recovery, including the mitigation of damage from future incidents, in recovery plans.

Task 5: Develop a transition plan for implementing and monitoring corrective actions. In partnership with key stakeholders, create a transition plan based on the jurisdictional public health agency lead or support roles to integrate implementation and monitoring of corrective actions into day-to-day agency operations.

Return to Crosswalk

Task 6: Assess and strengthen community resilience to future disasters. Coordinate with jurisdictional partners and stakeholders to evaluate and strengthen community resilience to future incidents by improving routine community functioning and reducing community vulnerability. Based on the known or anticipated health and social services recovery issues that the community will experience, integrate the necessary interventions for those issues and barriers into day-to-day business through inclusion in multiyear budgets, planning efforts, and staffing approaches.

Preparedness Resource Elements

P1: Procedures in place for continuous development and maintenance of partnerships with cross-sector community partners and stakeholders to support the restoration of access to public health, emergency management, health care, and mental/behavioral and environmental health services.

(See Capability 1: Community Preparedness)

P2: (Priority) Procedures in place to solicit feedback and recommendations from leaders in key sectors to improve community access to public health, emergency management, health care, mental/behavioral and environmental health, and human services. Key sectors may include

- Business
- Childcare
- Community and faith-based organizations
- Education
- Government
- Health care
- Housing and sheltering
- Media

P3: Corrective action plans based on jurisdictional public health agency lead or support roles that may include

- Mitigation plans to reduce damage from future incidents
- Jurisdictional and cross-sectoral models of community resilience to ensure the participation of all potential stakeholders in developing strategies to withstand and recover from future events
- Transition plan that identifies specific corrective actions, assigns them to responsible parties, and establishes targets for their completion

Return to Crosswalk

Capability 3: Emergency Operations Coordination

Definition: Emergency operations coordination is the ability to coordinate with emergency management and to direct and support an incident or event with public health or health care implications by establishing a standardized, scalable system of oversight, organization, and supervision that is consistent with jurisdictional standards and practices and the National Incident Management System (NIMS).

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Conduct preliminary assessment to determine the need for activation of public health emergency operations
- **Function 2:** Activate public health emergency operations
- **Function 3:** Develop and maintain an incident response strategy
- **Function 4:** Manage and sustain the public health response
- **Function 5:** Demobilize and evaluate public health emergency operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Distinguishes the need to identify and clarify the jurisdictional Emergency Support Function (ESF) #8 response role based on incident type and characteristics
- Incorporates the National Health Security Strategy and Crisis Standards of Care for public health activation
- Emphasizes the importance of supporting development of mission ready packages (MRPs) for mutual aid and understanding the Emergency Management Assistance Compact (EMAC)

For the purposes of Capability 3, partners and stakeholders may include the following:

- communicable disease programs
- emergency management agencies
- infection control programs
- preparedness and response programs
- public health agencies
- public health laboratories
- tribes and native-serving organizations
- volunteer organizations

Function 1: Conduct preliminary assessment to determine the need for activation of public health emergency operations

Function Definition: Identify the public health risks of an incident or event and coordinate with subject matter experts to help determine the scale of incident management operations.

Tasks

Task 1: Determine the public health response role. Coordinate with emergency management officials to determine if public health will have a lead response role, a supporting role, or no role based on identified or potential public health consequences.

Return to Crosswalk

Task 2: Determine response activation levels based on the complexity of the incident or event. Coordinate with emergency management officials in collecting and analyzing data to assess the situation and determine emergency response operations applicable to jurisdictional needs.

Task 3: Develop the public health incident management structure. Document a flexible and scalable public health incident management structure that is consistent with NIMS and is coordinated with the jurisdictional incident, unified, or area command structure.

Preparedness Resource Elements

P1: (Priority) Response procedures in place to detail how the agency manages and responds to situational awareness information that indicates when a jurisdictional incident with public health consequences requires an agency-level response.

Identify incidents where public health will function as the lead agency in coordination with other agencies or where public health will not function as the lead agency, but the incident has significant public health implications including localized incidents and incidents of national significance, which include Presidentially declared emergencies, major disasters, and catastrophes that pose a public health threat.

P2: (Priority) Maintain a roster of primary and backup individuals who will serve as incident commander or manager and other key roles within the jurisdictional incident management structure based on the incident public health agency lead or support role.

P3: Procedures in place for public health preparedness and response based on jurisdictional risk assessment (JRA) findings that are coordinated with the jurisdictional emergency management agency. Coordination with the jurisdictional emergency management agency may include

- Sharing identified public health risks, hazards, threats, and vulnerabilities to help identify public health incident management roles
- Communicating the availability of public health resources in relation to the projected impacts of identified jurisdictional public health risks, hazards, threats, and vulnerabilities
- Identifying the need to establish additional mutual aid agreements or other agreements with other public health organizations
- Consulting with subject matter experts including immunization, epidemiology, laboratory, surveillance, health care, chemical, biological, and radiological subject matter experts, and emergency management agency leadership to help inform the scope of public health involvement in an incident that may differ from those identified in the JRA

(See Capability 1: Community Preparedness and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P4: Scenario-specific and all–hazards, response-based procedures in place that describe incident response strategies based on the nature and scope of the incident including pandemic influenza, anthrax, other emerging infectious disease, natural disasters, and intentional incidents. Recommended procedures include

- Definition of public health incident management roles as necessitated by the incident or event
- Guidelines for when public health incident management roles must be filled, such as to support prevention, protection, mitigation, response, and recovery activities
- Safety implications of the incident, such as any hazardous conditions that could arise for responders and how to protect them
- Resources including personnel and equipment necessary to fulfill public health incident management roles

Return to Crosswalk

P5: Special event plans developed in coordination with the jurisdictional emergency management agency and other Emergency Support Function (ESF) #8 partners. Plan data may be submitted by the State Homeland Security Office on behalf of all state ESFs to the United States Department of Homeland Security (DHS) for Special Event Assessment Rating (SEAR) evaluation.

Skills and Training Resource Elements

S/T1: Personnel trained in incident management, as applicable to their role. At a minimum, personnel should complete the following NIMS courses

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Intermediate Incident Command System (ICS-300)
- Advanced Incident Command System (ICS-400)
- National Incident Management System, An Introduction (IS-700.a)
- National Response Framework, An Introduction (IS-800.b)

Equipment and Technology Resource Elements

E/T1: Primary and backup communications systems, which may include

- Cellular telephones with chargers
- Dual-band and P25 compliant radios (walkie-talkies)
- Fax machines
- Amateur (HAM) radio
- High-frequency radios
- Internet
- Non-technology dependent systems
- Satellite communication
- Telephones and dedicated telephone lines
- Television

Function 2: Activate public health emergency operations

Function Definition: Engage senior leadership and resources including technologies, physical space, and other assets to address an incident or event consistent with the NIMS and jurisdictional standards and practices.

Tasks

Task 1: Activate public health incident command and emergency management functions. Activate necessary public health functions and support mutual aid according to the public health incident management role and incident requirements.

Task 2: Identify personnel with the necessary skills to fulfill required incident command and public health incident management roles. Coordinate with emergency management agencies and other partners to develop staffing pools that include federal, regional, state, local, tribal, and territorial personnel with necessary public health expertise to serve as incident commander and other public health incident management roles.

Return to Crosswalk

Task 3: Designate personnel coverage for multiple operational periods. Develop continuous long-term staffing plans for required incident command and other public health incident management roles.

Task 4: Establish primary and alternate locations and virtual communication structures for the public health emergency operations center. Identify primary and backup physical space and secure necessary equipment, such as desks, lighting, power outlets, and internet access as well as virtual communication structures to support public health emergency operations.

Task 5: Assemble designated personnel at the appropriate emergency operations center(s). Notify personnel to report either physically or virtually to the public health emergency operations center (EOC) or jurisdictional EOC.

Preparedness Resource Elements

P1: (Priority) Procedures in place to manage, operate, and staff the public health EOC or public health functions within another EOC. Recommended procedures may include

- Statutes and authorities under which activities are carried out
- Differing activation levels, including who is authorized to activate the plan and under what circumstances
- Recall or assembly of required incident command and management personnel and verification that facilities are available and operationally ready for assembled personnel
- Development of communication plans and supporting technology systems
- Verification that virtual communication structures are available and operational
- Identification of functional roles and responsibilities anticipated for internal and external agencies, organizations, departments, and positions, such as strike teams, task forces, or other units
- Logistics support and other resources necessary to implement the emergency operations procedures

P2: (Priority) Mutual aid agreements or other agreements, such as local agreements, EMAC, and health care coalitions, as applicable, between public health agencies and response partners to support public health response related activities (ESF #8) across jurisdictions. Agreements may include

- Development of public health MRPs detailing public health resources for use during mutual aid deployments
- Agreements with external organizations to help support specific public health functions, such as the American Red Cross, community emergency response team (CERT), Voluntary Organizations Active in Disaster (VOAD), and Mobile Medical Response (MMR)
- Procedures for coordinating investigation and response operations across agencies
- Procedures for requesting and providing assistance
- Procedures, authorities, and rules for payment, reimbursement, and allocation of cost
- Notification procedures for activation of memoranda of understanding (MOUs) or other agreements
- Workers compensation
- Treatment of liability and immunity
- Recognition of qualifications and certifications
- Resource sharing agreements as necessary

(See Capability 15: Volunteer Management)

Return to Crosswalk

P3: (Priority) Job action sheets or equivalent documentation for incident command positions and other public health incident management roles during a public health emergency.

P4: Procedures in place to ensure personnel and equipment arriving at the incident or event can check in and check out at various incident locations. Recommended documentation includes the Incident Command System Form 211—Incident Check-In List or equivalent forms.

Skills and Training Resource Elements

S/T1: (Priority) Personnel trained in NIMS training, such as ICS 300 and ICS 400, as applicable based on discipline, level, and jurisdictional requirements.

S/T2: Personnel identified in advance of an incident or event who can adequately fill, lead, or support public health incident management roles, including arrangements to staff multiple emergency operations centers at the agency, local, and state levels, as necessary.

S/T3: Personnel participation in applicable jurisdictional emergency management training and certification courses.

Equipment and Technology Resource Elements

E/T1: Backup equipment and infrastructure, such as generators, facilities, and security systems in the event of system failure or power loss in the public health emergency operations center.

E/T2: Primary and backup communications equipment to transmit information inside and outside the emergency operations center, with contact numbers and radio frequencies stored with corresponding equipment. Communications equipment may include

- Cellular telephones with chargers
- Dual-band and P25 compliant radios (walkie-talkies)
- Fax machines
- High-frequency radios
- Internet
- Non-technology dependent systems
- Satellite communication
- Telephones and dedicated telephone lines
- Television

(See Capability 6: Information Sharing)

E/T3: Information technology equipment in quantities sufficient to meet incident or event objectives, such as projectors, computers, and audio/video teleconferencing equipment.

E/T4: Information technology systems in quantities sufficient to meet incident or event objectives. Recommended systems may include WebEOC, inventory tracking systems, such as the Inventory Management and Tracking System (IMATS), and the jurisdiction's immunization information system.

Return to Crosswalk

Function 3: Develop and maintain an incident response strategy

Function Definition: Produce or provide input to incident action plans containing response strategies appropriate to the incident and as described in NIMS during one or more operational periods.

Tasks

Task 1: Develop incident action plans. Produce or contribute to (as appropriate for the public health incident management role) an incident action plan that receives approval prior to each operational period.

Task 2: Update and share incident action plans. Revise and brief personnel on the incident action plan by the start of each new operational period.

Task 3: Disseminate incident action plans. Make incident action plans available to relevant public health response personnel, volunteers, and partner agencies according to emergency operations protocols.

Preparedness Resource Elements

P1: (Priority) Capacity for producing incident action plans that document accomplishments from the previous operational period as well as goals, objectives, and priorities for the next operational period.

P2: Incident action plans, with dissemination and briefings, for all personnel at the start of each new operational period.

Function 4: Manage and sustain the public health response

Function Definition: Direct ongoing public health emergency operations to sustain the public health and health care response for multiple operational periods and concurrent responses.

Tasks

Task 1: Coordinate public health and health care emergency management operations. Ensure coordination among public health agencies, the health care system, and other relevant stakeholders according to incident requirements.

Task 2: Track public health resources. Ensure systems are in place to track and account for all public health resources during the public health response.

Task 3: Maintain health situational awareness (HSA). Compile information gathered from public health, health care, and other stakeholders, such as fusion centers to support a common operating picture.

Task 4: Conduct shift change briefings. During shift changes, formally share information between outgoing and incoming public health personnel to communicate priorities, status of tasks, and safety guidance.

Task 5: Develop continuity of operations plan(s). Identify response priorities to ensure the continuation and recovery of critical public health functions.

Return to Crosswalk

Preparedness Resource Elements

P1: Standard operating procedures in place to manage a response. Recommended procedures include

- Procedures to account for personnel, time, equipment, and other items used during the public health response
- Procedures for media engagement, such as managing media inquiries about the incident and using the media to disseminate critical information
- Procedures for situation reports and shift change briefings
- Procedures to collect critical or required information
- Supporting templates for key operations center activities, including situation reports, shift change briefings, call logs, and activity logs

P2: Procedures in place for information sharing with fusion centers or comparable state centers or agencies in order to provide and receive relevant intelligence information that may influence the response.

P3: Common operating picture that facilitates coordinated information sharing among public health, the health care system, and other relevant stakeholders. Establish key indicators, critical information requirements, and essential elements of information to assist with timing of notifications, alerts, and responses

P4: (Priority) Procedures in place to ensure the continued performance of pre-identified essential functions during a public health incident. Recommended procedures may include

- Identification and definition of essential services needed to sustain public health agency mission and operations
- Protocols to sustain essential services, regardless of the nature of the incident (all-hazards planning)
- Identification of alternate or COOP worksites
- Identification and definition of positions, skills, and personnel needed to continue essential services and functions (human capital management)
- Protocols to reduce workforce for scaled-down operations
- Protocols for devolution of uninterruptible services for scaled-down operations
- Protocols for reconstitution of uninterruptible services
- Contingencies to continue operations when personnel have limited access to facilities because of social distancing measures or other staffing or security concerns
- Protocols for broad-based implementation of social distancing policies to prevent the spread of infectious disease or for other reasons based on the incident
- Identification of agency vital records, such as legal documents, payroll, and personnel assignments that must be preserved in order to support essential functions or for other reasons

(See Capability 2: Community Recovery and Capability 6: Information Sharing)

Return to Crosswalk

Skills and Training Resource Elements

S/T1: Personnel trained on any jurisdictionally identified software needed to support emergency operations centers, such as WebEOC prior to an incident.

S/T2: Personnel trained on public health agency procedures for emergency operations as documented in standard operating procedures, COOP plan, demobilization plan, and emergency operations plan with an understanding of their public health incident management role(s), if any, during a public health response.

Function 5: Demobilize and evaluate public health emergency operations

Function Definition: Release and return resources no longer required by the incident or event to their ready state and assess efforts, resources, actions, leadership, coordination, and communication to implement continuous improvement activities. Complete evaluation activities throughout response operations, and finalize response activities with after-action processes.

Tasks

Task 1: Return public health resources and staffing to their prior "ready state" of operations. Archive records and restore systems, supplies, and staffing to pre-incident readiness.

Task 2: Conduct final incident closeout of public health operations. Turn over documentation, conduct hot washes and incident debriefings, and identify final closeout requirements with responsible agencies and jurisdiction officials.

Task 3: Produce after-action report(s). Conduct after-action processes for public health operations in partnership with other emergency operations stakeholders to identify areas of success, promising practices, and opportunities for improvement.

Task 4: Develop improvement plan(s). Document priorities and identify corrective actions assigned to public health.

Task 5: Implement and track progress on improvement plan(s). Complete the corrective actions assigned to public health and establish a system to track completion and effectiveness of corrective actions.

Preparedness Resource Elements

P1: (Priority) Procedures in place for demobilization of public health operations. Recommended procedures may include

- Procedures to scale down operations, including transitioning workforce and services back to their normal levels, and returning or releasing equipment and other resources
- General information about the demobilization process
- Responsibilities or agreements for reconditioning equipment or resources
- Responsibilities for implementing the demobilization plan, the systematic approach for an orderly, safe, and efficient return of a resource to its original status (NIMS definition)
- General release priorities meaning resources, such as personnel, services, or equipment to be returned and detailed procedures for releasing those resources
- Directories, including maps and telephone listings

Return to Crosswalk

P2: Incident closeout briefing for the public. Briefings may include

- Incident summary
- Lasting implications of major events
- Continuing activities or corrective actions that will not be completed under response operations
- Opportunity for discussion to bring up any concerns from agency officials
- Final evaluation of incident management by agency officials
- Team performance evaluation

P3: After-action report and improvement plan. Recommended elements include

- Executive summary
- Event overview
- Event summary
- Observations (strengths or areas for improvement)
- Analysis of capabilities
- Conclusion
- IP, recommended to include (at a minimum)
  - Identification of the capability being assessed
  - Observation
  - Title
  - Recommendation
  - Corrective action description
  - Capability element
  - Primary responsible agency
  - Agency point of contact
  - Start date
  - Completion date

Skills and Training Resource Elements

S/T1: Public health personnel who will evaluate incident responses, including development of the AAR and IP or lead exercises have an understanding of Homeland Security Exercise and Evaluation Program (HSEEP) policies, procedures, and terminology. Personnel should have experience in administration, design, development, evaluation, and improvement planning for exercises. Recommended trainings may include

- FEMA Emergency Management Institute Training: An Introduction to Exercises (IS.120.A), Exercise Evaluation and Improvement Planning (IS-130), and Exercise Design (IS-139)
- HSEEP training
- Incident Command System Form 221-Demobilization Checkout

S/T2: Personnel trained in demobilization procedures as relevant to the public health incident management role.

Return to Crosswalk

Capability 4: Emergency Public Information and Warning

Definition: Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management personnel.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Activate the emergency public information system
- **Function 2:** Determine the need for a Joint Information System
- **Function 3:** Establish and participate in information system operations
- **Function 4:** Establish avenues for public interaction and information exchange
- **Function 5:** Issue public information, alerts, warnings, and notifications

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Promotes the need to leverage social media platforms for issuing emergency public information and warnings
- Clarifies conditions for establishing a virtual Joint Information Center (JIC) and Joint Information System (JIS)
- Includes content to identify and reach populations at risk to be disproportionately impacted by incidents and those with limited access to public information messages

For the purposes of Capability 4, partners and stakeholders may include the following:

- 911 authority
- community and faith-based organizations
- elected officials
- emergency management agencies
- emergency medical services (EMS)
- health care organizations
- media organizations
- poison control centers
- public health agencies
- volunteer organizations

Function 1: Activate the emergency public information system

Function Definition: Notify and assemble key public information personnel and potential spokespersons identified prior to an incident to provide information to the public during an incident.

Tasks

Task 1: Identify key public information personnel. Identify public information officers (PIOs), spokespersons, and trained support personnel, such as subject matter experts to implement jurisdictional public information and communication strategies.

Task 2: Identify a primary and alternate physical or virtual JIC. Establish physical and virtual structures to support the creation and dissemination of health alerts and public information operations.

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Task 3: Mobilize PIOs, spokespersons, and support personnel. Notify public information and communication teams of the need to be on call or report for duty within incident-appropriate timeframes, including no-notice events.

Task 4: Establish roles and responsibilities of personnel to convey public information. Assemble public information personnel at a physical location or virtually to establish roles and responsibilities.

Task 5: Ensure personnel are trained in the functions they may fulfill. Provide public information and communication education and training to PIOs, spokespersons, and support personnel according to jurisdictional need.

Task 6: Support local public health systems with the implementation of emergency communications. Clarify state, local, tribal, and territorial public health information roles and confirm communication support and coordination needs.

Preparedness Resource Elements

P1: (Priority) Procedures in place to document roles and responsibilities for PIOs, spokespersons, and support personnel based on the incident and subject matter expertise.

P2: (Priority) Message templates and risk communication message development to address identified jurisdictional risks and vulnerabilities related to incident characteristics. Recommended templates may include

- Stakeholder identification
- Potential stakeholder questions and concerns
- Key messages to address stakeholder questions and concerns
- Common sets of underlying concerns

P3: Primary and alternate physical locations or virtual structures to support the creation and dissemination of health alert and other emergency public information and warning operations. Personnel assembly can occur at a physical location, like an emergency operations center (EOC), virtual location, such as conference calls or web-based interfaces, like WebEOC, or combination of both physical and virtual locations.

(See Capability 3: Emergency Operations Coordination)

P4: Current roster or call-down lists with pre-identified personnel to participate in key emergency communications functions, including a minimum of one backup per role, as necessary.

P5: Procedures in place for personnel to notify and report for duty. Recommended notification procedures may include

- Notification methods, such as health alert network, e-mail, and other personnel notification methods
- Personnel notification time frame (how quickly personnel will be notified)
- Personnel reporting times and locations (may be virtual)

P6: Job action sheets that detail specific tasks for personnel and volunteer communications roles.

(See Capability 3: Emergency Operations Coordination and Capability 15: Volunteer Management)

Return to Crosswalk

P7: Systems and procedures to mobilize communication activities and roles applicable to the incident or event, such as information gathering, information dissemination, operations support, and liaison. One or more individuals may conduct activities and roles, which include

- Fact gathering
- Rumor control or message testing
- Monitoring and publishing content across print, Internet, social, and other media
- Providing support to speakers, such as developing talking points, speeches, and visuals
- Managing or responding to public inquiries using hotlines or other channels

(See Capability 3: Emergency Operations Coordination)

P8: Emergency communication implementation and coordination support to local public health systems from state and territorial jurisdictions.

(See Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: (Priority) Public information personnel trained in relevant National Incident Management System (NIMS) courses, which may include

- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- National Incident Management System, an Introduction (IS-700.a)
- National Incident Management System Public Information Systems (IS-702.a)
- National Response Framework, An Introduction (IS-800.b)

S/T2: (Priority) Public information personnel able to develop key messages using the principles of crisis and emergency risk communication. Within six months of hire and at least once every five years thereafter, the following trainings are recommended for completion

- CDC's Crisis and Emergency Risk Communication (CERC) Basic Training
- CERC training administered by CDC personnel or local personnel already trained by CDC personnel

S/T3: PIO able to complete responsibilities, which may include

- Representing and advising the incident commander as part of the command personnel on all public information matters relating to communication management for the incident, and monitoring and handling media and public inquiries
- Managing day-to-day operations of the JIC and functioning within a JIS
- Coordinating with PIOs from participating government departments and organizations to manage resources and avoid duplication of efforts

Equipment and Technology Resource Elements

E/T1: Dedicated phone line(s) to receive and address inquiries from the media, stakeholders, and the public.

E/T2: Capacity for 24/7 health alerting (using phone or other alerting or notification methods), including maintenance, licensing, and mechanisms, such as contracts in place to purchase media time or short system messaging (SMS) code, as necessary.

E/T3: Redundant power supply to support 24/7 alerting and public messaging capacity.

Return to Crosswalk

E/T4: Communication devices to support partnerships with emergency management or other local authorities. Communication devices may include

- Amateur radios
- Government Emergency Telecommunications Service (GETS) card issued by the U.S. Department of Homeland Security (DHS)
- Satellite phones
- Walkie-talkies, such as P25 compliant radios
- Other wireless devices

Function 2: Determine the need for a Joint Information System

Function Definition: Coordinate with emergency management agencies to determine the need for and scale of a JIS, including, if appropriate, activation of a new public health JIC. Participate with other jurisdictional JICs to combine information sharing abilities and coordinate messages.

Tasks

Task 1: Coordinate with jurisdictional emergency management to establish a public health JIC or a virtual JIC and participate in a JIS as needed. Activate a public health JIC or a virtual JIC, as applicable to the incident, and coordinate with emergency management to determine the need for a JIS.

Task 2: Ensure appropriate participation from public health communications representatives in the jurisdictional EOC. If a public health JIC is not activated for the incident, identify a public health communication representative, such as a PIO to participate in the jurisdictional EOC to ensure public health messaging capacity is represented.

Task 3: Coordinate public information messages through four common functions. Assign leads to the four common functions: information gathering, information dissemination, operations support, and liaison roles to public information personnel. Ensure coverage for extended operational periods, as applicable.

Preparedness Resource Elements

P1: Procedures in place to activate a JIC or virtual JIC connecting public information agencies or personnel through telephone, Internet, or other technologies and means of communication.

(See Capability 3: Emergency Operations Coordination)

P2: Standard operating procedures in place to request additional emergency public information and warning resources including personnel and equipment, and replace inoperable equipment to ensure continuity of operations through the jurisdictional incident management system.

P3: Decision support matrix to help determine when to scale up or scale down JIS operations. Recommended considerations may include

- Contingencies if incident information needs exceed the public health agen cy resources
- Procedures in place to detail how the public health agency will participate in the jurisdictional JIC or JIS if the response involves multiple organizations requiring coordinated messaging and spokespersons

Return to Crosswalk

Skills and Training Resource Elements

S/T1: Personnel or volunteers from partner agencies who will support information gathering, information dissemination, operations support, and liaison roles during an incident.

S/T2: Personnel or volunteers from partner agencies who have awareness-level training specific to media operations during an incident. Media operations may include television, Internet, radio, social media, newspapers, and other channels.

Equipment and Technology Resource Elements

E/T1: **(Priority)** Minimum components of a virtual JIC may include

- Electronic communications equipment to exchange information within the jurisdiction and with CDC in real time, as possible
- Plans for continuity of operations if equipment is inoperable
- Shared site, mechanism, or system to store electronic files of JIC products, e-mail distribution lists, incident information, and scheduling

E/T2: Supporting infrastructure for state, local, tribal, and territorial jurisdictions to send and receive information, with the ability to meet access and functional needs guidelines. Infrastructure may include

- Cellular phones
- Clocks
- Computers and printers
- Contact information for state and local officials and media
- Fax machines
- Internet access
- Phones and multiple phone lines
- Radio (dual-band, HAM, or high-frequency)
- Recording devices for both radio and television
- SMS text
- Television
- Video conferencing equipment

Function 3: Establish and participate in information system operations

Function Definition: Monitor jurisdictional media, conduct press briefings, and provide rumor control for media outlets using the principles of NIMS for organizing and coordinating incident-related communications.

Tasks

Task 1: Participate in public information sharing. Develop, recommend, and execute approved public health communication plans and strategies on behalf of the incident command or unified command structure based on the public health incident management role. Before sharing information with the public, collect, evaluate, and verify all information and obtain approval from authorized officials, such as health officer or incident commander.

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Task 2: Control rumors. Control myths and rumors within the jurisdiction using media and digital outlets, including television, Internet, radio, social media, and newspapers.

Task 3: Provide a single point for dissemination of information for public health and health care issues. Release public health and health care information through pre-identified procedures based on jurisdictional processes, such as systems and spokespersons in coordination with the JIC.

Preparedness Resource Elements

P1: Procedures in place for when the public health agency may designate a lead PIO or provide public information support within emergency operations plans, job action sheets, or other applicable documentation.

P2: Procedures in place to track and monitor media, which may include

- Tracking media contacts and public inquiries, including contact, date, time, query, and outcome
- Monitoring media coverage to ensure information is accurately relayed
- Correcting misinformation before the next news cycle
- Addressing public health and health care concerns received from jurisdictional media interests
- Maintaining media contact lists and protocols for media engagement

Skills and Training Resource Elements

S1: Public information personnel trained in incident management and information systems operations. Relevant trainings may include

- National Incident Management System (IS-701.a)
- Emergency Management Institute G291—Joint Information System/Joint Information Center Planning for Tribal, State, and Local Planning Information Officers
- Emergency Management Institute PIO trainings

Equipment and Technology Resource Elements

E/T1: Equipment and digital media accounts that are accessible to PIOs or spokespersons in order to receive messaging from the jurisdiction's public health alert system or network.

(See Capability 3: Emergency Operations Coordination or Capability 6: Information Sharing)

Function 4: Establish avenues for public interaction and information exchange

Function Definition: Provide methods for the public to contact the public health agency with questions and concerns. Methods may include

- Call centers
- Help desks
- Hotlines
- Instant messaging
- Social media
- Text messaging
- Websites

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Tasks

Task 1: Establish systems for managing public and media inquiries. Implement scalable methods, such as Internet sites, call centers, poison control centers, non-emergency lines, such as 211 or 311, and social media to respond to public and media inquiries, as needed, for the incident.

Task 2: Post incident-related information on the public health agency website. Establish an Internet presence to inform and connect with the public that adheres to the principles of CERC.

Task 3: Use social media platforms and text messaging. Implement social media platforms, such as Twitter and Facebook and opt-in targeted notifications through texting, when and if possible, for public health messaging to the public.

Task 4: Identify, protect, and ensure information exchange with disproportionately impacted populations. Use geographic information systems (GIS), demographics, and epidemiological data to understand the complexities of the emergency and the response and to identify appropriate methods and sources, such as trusted spokespersons to protect, reach, and engage at-risk individuals with access and functional needs who may be disproportionately impacted by the incident.

Preparedness Resource Elements

P1: Procedures in place to activate and manage designated inquiry line(s), as applicable. Recommended procedures may include

- Diversion of unnecessary calls away from the community 911 system by establishing call centers or by other methods
- Diversion of non-critically ill patients away from the health care system, including the use of public information, advice, or triage lines
- Provision of updated public information regarding public health agency actions and recommendations

P2: Procedures in place to activate call centers with community partners, as needed. Recommended procedures may include

- Criteria for activating call centers
- Designation of persons to activate the call center system
- Designation of call center leader
- Process for call center system activation
- Procedures to detail how the call center will interface with the jurisdiction's incident management system, to include the JIC
- Call center scripts or message maps for call center personnel
- Coordination of call center scripts with other messages
- Contact information for community partners for example, providing a public health center with poison control center contact information
- Processes to assess staffing needs
- Processes for staffing, increased hours, and demobilization of call centers

Return to Crosswalk

P3: Procedures in place for the usage of CDC-INFO or nurse triage lines and poison control centers as resources to increase response capacity for public and health care provider inquiries in emergency and natural disaster incidents, as applicable to the jurisdiction.

(See Capability 6: Information Sharing)

P4: Procedures in place to monitor, manage, and use social media, which may include

- Addressing questions, myths, and misconceptions
- Collecting and reviewing digital media metrics, such as click-through rates, impressions, followers, likes, and shares
- Coordinating social media messaging with call center scripts
- Creating and clearing posts, including a timeframe or schedule for adding new posts
- Evaluating social media engagement and reach
- Hyperlinking to other relevant websites
- Promoting social media channels
- Using geotags and push notifications to target social media messages to users in impacted areas

P5: Message development guidelines for social media, which may include

- Considerations for target audiences
- Use of plain language
- Character limits for messages
- Sign language interpreter and captioning for video messaging
- Audio conversion for scrolled messaging
- Actions the public can and should take during an incident

Skills and Training Resource Elements

S/T1: Public information personnel trained in the use of social media, technology, and health communication.

S/T2: Public information personnel who have completed NIMS Communications and Information Management training (IS-704).

Equipment and Technology Resource Elements

E/T1: Information technology or telephonic equipment to support the scalability of the inquiry line, as needed, for the incident (a transferred call occupies a phone channel until the call is completed).

Function 5: Issue public information, alerts, warnings, and notifications

Function Definition: Use CERC principles to disseminate critical health and safety information to alert the media, public, and other stakeholders to potential health risks and reduce the risk of exposure to ongoing and potential hazards.

Tasks

Task 1: Comply with jurisdictional legal guidelines when communicating information. Prevent communication of information that is protected for national security or law enforcement purposes or that may infringe on individual or entity rights.

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Task 2: Disseminate information to the public using pre-established message maps. Disseminate approved messages to the public through multiple mechanisms, and ensure that languages and formats of information account for the access and functional needs of individuals, which may include individuals

- Who are deaf or hard of hearing
- With vision impairments
- With limited English proficiency
- From diverse cultural backgrounds
- With cognitive limitations
- Who do not use traditional media

Task 3: Disseminate information to responder organizations. Coordinate and transmit health-related information to responder organizations through secure messaging platforms.

Preparedness Resource Elements

P1: Documented and approved intra- and inter-jurisdictional legal authorities to avoid communicating information that is protected for national security or law enforcement purposes or that may infringe on individual or entity rights.

P2: Procedures in place to identify points of contact and establish a clearance process to verify and approve communication products, including talking points, social media messages, public information, and external-facing documents.

P3: Documented information to help populations at risk of being disproportionately impacted by an incident understand personal preparedness, what services are available, and where and how to obtain services. Consider the use of multiple media, multilingual materials, and alternative formats as well as the cultural appropriateness and age appropriateness of information.

P4: Procedures in place to address populations that may be disproportionately impacted by the incident, including at-risk populations with access and functional needs, in the development of informational materials.

P5: Procedures in place to reach rural or isolated populations.

Skills and Training Resource Elements

S/T1: Information technology personnel with necessary skills to support and sustain the jurisdictional health alert network or system.

(See Capability 6: Information Sharing)

S/T2: Personnel trained in health communication and cultural competency.

Return to Crosswalk

Capability 5: Fatality Management

Definition: Fatality management is the ability to coordinate with organizations and agencies to provide fatality management services. The public health agency role in fatality management activities may include supporting

- Recovery and preservation of remains
- Identification of the deceased
- Determination of cause and manner of death
- Release of remains to an authorized individual
- Provision of mental/behavioral health assistance for the grieving

The role may also include supporting activities for the identification, collection, documentation, retrieval, and transportation of human remains, personal effects, and evidence to the examination location or incident morgue.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Determine the public health agency role in fatality management
- **Function 2:** Identify and facilitate access to public health resources to support fatality management operations
- **Function 3:** Assist in the collection and dissemination of antemortem data
- **Function 4:** Support the provision of survivor mental/behavioral health services
- **Function 5:** Support fatality processing and storage operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Clarifies importance of identifying the public health agency role in fatality management and describes potential fatality management lead, advisory, and support roles
- Aligns the fatality management definition to the existing federal definition as recommended by the U.S. Department of Health and Human Services' (HHS) Disaster Mortuary Operational Response Team (DMORT)
- Updates resources to improve coordination, accuracy, and timeliness of electronic mortality reporting

For the purposes of Capability 5, partners and stakeholders may include the following:

- emergency management agencies
- emergency medical services (EMS)
- federal authorities
- funeral homes
- funeral industry
- health care coalitions
- health care organizations
- hospitals
- law enforcement agencies
- medical examiner or coroner offices
- medicolegal authorities
- public health agencies
- subject matter experts (SMEs)[1]
- vital statistics partners

[1] Including SMEs with expertise in epidemiology, laboratory, surveillance, community cultural or religious beliefs, or burial practices

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Function 1: Determine the public health agency role in fatality management

Function Definition: Coordinate with jurisdictional authorities and partners to estimate and characterize potential fatalities and the impact of these fatalities on fatality management needs, resources, and activities to determine the public health agency role in fatality management.

Tasks

Task 1: Estimate fatality management needs based on jurisdictional risks. Characterize potential fatalities based on findings from jurisdictional risk assessment(s) and determine the resources and activities needed to manage potential fatalities based on the normal expected fatality rate and fatalities related to the incident.

Task 2: Clarify, document, and communicate the jurisdictional public health agency role(s) in fatality management. Coordinate with subject matter experts and cross-disciplinary partners and stakeholders to clarify, document, and communicate the public health agency role in fatality management based on jurisdictional risks, incident needs, and partner and stakeholder authorities.

Preparedness Resource Elements

P1: (Priority) Fatality management procedures that are scaled to address potential fatality scenarios based on jurisdictional hazards and risks. Jurisdictional fatality management procedures should be included in relevant jurisdictional emergency operation plans.

(See Capability 1: Community Preparedness)

P2: (Priority) Definition of the jurisdictional public health agency role for fatality management established in coordination with jurisdictional authorities, subject matter experts, and other cross-disciplinary stakeholders. Recommended activities to establish roles may include

- Identification of jurisdictional fatality management lead authority (individual or organization)
- Identification of public health liaison(s) to support fatality management operations and leadership
- Consideration of incident characteristics, existing plans, services, infrastructure, and information sharing needs in coordination with jurisdictional authorities and partners to determine public health support roles
  - Incident characteristics
  - Magnitude of incident, including the estimated number of decedents
  - Condition of human remains (intact or fragmented human remains, meaning comingled, decomposed, charred, or mutilated)
  - Rate of recovery (rapid, moderate, or slow)
  - Recovery area complexity, including the extent of gridding necessary and whether recovery area boundaries are known or unknown
  - Presence of hazards, including chemical, biological, radiological, environmental, or communicable disease hazards
  - Disaster site location characteristics, such as fixed or distributed location and the need for excavation or debris removal
  - Public health or law enforcement community constraints, such as limitations on public gatherings or establishment of curfews

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- Event occurrence, such as single event at one location, single event at multiple locations, or recurring event at multiple locations
- Decedent identification needs, including antemortem data collection, postmortem data collection, requirement to issue death certificates, and communication with next of kin
  - Existing plans, services, and infrastructure
  - Medical examiner or coroner services and availability of interoperable case management system(s), mass fatality database(s), and electronic death registration system(s) (EDRS)
  - Procedures to coordinate with other fatality management, funeral industry, and the American Red Cross to support investigations, relieve health care facilities, and support family, cultural, religious, and bereavement needs
  - Death certification procedures to indicate that death is associated with a specific event, if applicable
  - Public health laboratory plans for detection, characterization, confirmation, and reporting of public health threats based on testing of clinical specimens, food, water, and other environmental samples
  - Health and safety plans for facilities and tasks involving hazardous work, such as complex recovery operations
  - Plans to account for recovered remains and materials
  - Family management services, including family assistance centers and long-term family management support
  - Mental/behavioral services and grief or bereavement counseling for survivors, responders, next of kin, and affected communities
  - Plans to coordinate with hospitals, health care facilities, and designated morgue facilities
  - Information sharing needs
  - Public messaging to identify human remains that should not be moved or manipulated
  - Public messaging to communicate expectations for recovery, care, identification, and release of human remains
  - Public messaging to communicate funeral capacity
  - Information sharing with applicable jurisdictional committees, such as maternal mortality review or child fatality review committees
  - Call centers to coordinate the collection of missing persons information and assist in prompt identification of remains
  - Mortality reporting and information sharing requirements
  - Press releases and social media announcements
  - Death certificate record release to families
  - Notification to the Federal Emergency Management Agency (FEMA), Veterans Affairs (VA), or other agencies and organizations to facilitate funeral or other benefits

P3: Written agreements, such as contracts or memoranda of understanding (MOUs) or co-signed plans among jurisdictional stakeholders that support coordinated fatality management activities to leverage shared resources, facilities, services, and other support based on identified roles.

P4: (Priority) Procedures in place to designate lead authorities to request resources based on ongoing assessments of the incident or event needs for example, public health agency response plans, coordinated with the jurisdictional emergency management agency, to facilitate state requests

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for federal resources through HHS Regional Emergency Coordinators (RECs). Procedures for resource requests may include

- County or jurisdictional mass fatality protocols that indicate thresholds for requesting additional resources, including requests from local to state, state to state, and state to federal
- State, regional, and federal resources, including HHS DMORTs, to be requested when anticipated resource needs exceed local capacity
- Mutual aid agreements for resource requests, for example Emergency Management Assistance Compact (EMAC) or MOUs through appropriate channels, such as EMAC coordinator and emergency management

(See Capability 3: Emergency Operations Coordination and Capability 10: Medical Surge)

P5: Procedures in place, based on jurisdictional public health agency role(s), to support activities in coordination with partners and stakeholders.

(See Capability 1: Community Preparedness and Capability 13: Public Health Surveillance and Epidemiological Investigation)

Skills and Training Resource Elements

S/T1: Personnel trained on mass fatality or fatality management through courses offered nationally, by the state's emergency management agency, the public health agency, or other partners, as applicable. Recommended trainings may include

- Center for Domestic Preparedness: Healthcare Leadership for Mass Casualty Incidents (MGT-901)
- Emergency Management Institute: Mass Fatalities Incident Response Course (G-386)
- FEMA Emergency Support Function #8—Public Health and Medical Services (IS-808)
- Rural Domestic Preparedness Consortium: Mass Fatalities Planning and Response for Rural Communities (AWR-232)

Equipment and Technology Resource Elements

E/T1: Personal protective equipment (PPE), such as protective clothing and respiratory equipment necessary to support fatality management procedures and activities.

(See Capability 14: Responder Safety and Health)

E/T2: Human remains pouches, facilities, and other equipment and locations to store human remains.

Function 2: Identify and facilitate access to public health resources to support fatality management operations

Function Definition: Develop recommendations to identify and facilitate access to resources, such as personnel and subject matter experts, record keeping, and physical space to address fatality management needs resulting from an incident in accordance with public health agency jurisdictional roles and standards outlined in jurisdictional fatality management procedures.

Tasks

Task 1: Assess incident data. Assess incident data to develop public health fatality management activity guidance and define resource needs.

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Task 2: Develop and share incident-specific public health fatality management recommendations. Coordinate with jurisdictional, regional, private, and federal stakeholders as defined in the jurisdictional fatality management procedures to make incident-specific recommendations regarding the safe and efficient recovery, processing, reporting, storage, and final disposition of human remains.

Task 3: Initiate and coordinate public health support for fatality management operations. Coordinate with identified stakeholders to operationalize strategies as defined in the jurisdictional fatality management procedures and share incident recommendations for managing human remains.

Preparedness Resource Elements

P1: (Priority) Procedures in place to collect and analyze incident data and develop recommendations for safe and efficient fatality management operations.

P2: (Priority) Procedures in place to identify and support public health agency lead or support activities for fatality incident management, including continuity of operations, based on incident data and recommendations. Public health agency activities for fatality incident operations, communication, and community support may include

- Mass fatality incident operations activities
  - Coordinating with law enforcement and forensics agencies, such as medical examiners or coroners
  - Participating in joint criminal-epidemiological (Crim-Epi) investigations
  - Participating with the search and recovery of human remains
  - Providing human health hazard mitigation and risk prevention and control recommendations
  - Maintaining a roster of additional personnel
  - Providing training on appropriate PPE
  - Supporting security and preserving the mass fatality incident site
  - Identifying multiple sites for interim storage and disposition of human remains
  - Obtaining additional refrigerated space or equipment
  - Managing the security and preservation of remains
  - Implementing a tracking system for the identification of recovered remains
  - Collecting and analyzing mass–fatality, incident-related mortality surveillance data
  - Completing death certificates of decedents
- Communications and guidance activities
  - Using communications systems to rapidly disseminate and receive incident health alerts
  - Disseminating public communications, including the use of social media
  - Providing guidance to the public on health and safety issues involving hazards and potential communicable disease(s)
  - Providing guidance to the public on what to do if they find or know of the location of human remains, such as guidance to not move bodies from the scene
  - Providing guidance on health and safety issues to prevent responder mortality
  - Coordinating public affairs and establishing call centers

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- Community resilience and support activities
  - Organizing family assistance center(s)
  - Facilitating the provision of funeral or other benefits for eligible next of kin from FEMA, VA, or other agencies and organizations
  - Providing access to grief or bereavement and spiritual counseling
  - Providing mental/behavioral health services to ease traumatic reactions experienced by responders and the public

(See Capability 4: Emergency Public Information and Warning, Capability 12: Public Health Laboratory Testing, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 15: Volunteer Management)

P3: Procedures in place to share information with fatality management partners, including fusion centers or comparable centers and agencies, emergency operations centers (EOCs), and epidemiologist(s), in order to provide and receive relevant intelligence information that may impact the response.

(See Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: Personnel trained on functional activities based on designated jurisdictional fatality management roles.

Equipment and Technology Resource Elements

E/T1: Materiel to manage fatality operations based on the incident. Materiel may include

- Standard and hazardous materials (HazMat) PPE and clothing, such as gloves, boots, coats, hard hats, rain suits, and respirators
- Human remains pouches (appropriate number and type)
- Refrigerated storage
- Tents
- Equipment, supplies, and human remains storage
- Marking flags or barricade tape
- Barcoded toe tags
- Biohazard bags and boxes
- Photography equipment
- Gridding, laser survey, and global positioning systems
- Communication devices, such as radios and cell phones
- Equipment for scene documentation
- Hazard assessment or monitoring and mitigation unit
- Radiation survey equipment
- X-ray and laboratory equipment

E/T2: Data tracking systems that may be available through the medical examiner's or coroner's office to collect and manage data, which may include

- Missing person data
- Antemortem data, including DNA, medical or dental records, reported tattoos, and physical belongings
- Postmortem data, including human remains and scene data

(See Capability 6: Information Sharing)

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E/T3: Death reporting systems available to ensure initial reporting (line lists) and accurate and timely completion of death certifications. Death reporting systems may include electronic mass fatality case management and incident systems, medical examiner or coroner case management systems, and electronic death registration systems.

Function 3: Assist in the collection and dissemination of antemortem data

Function Definition: Assist the jurisdictional fatality management lead authority and other partners including regional partners, as necessary, to gather and disseminate antemortem data through family assistance centers or other models, as defined in jurisdictional fatality management procedures.

Tasks

Task 1: Establish and refine antemortem data management processes. Coordinate with partners, such as family assistance centers to establish and refine processes and methods to collect and share antemortem data.

Task 2: Assemble necessary resources for antemortem data management. Coordinate with partners to support the identification and assembly of resources to collect and share antemortem data.

Task 3: Collect and share antemortem data with partners. Coordinate with partners to assist in the collection and dissemination of antemortem data to law enforcement, other agencies, and families of the deceased.

Task 4: Support electronic mortality reporting. Support recording and reporting of antemortem data through electronic systems or other information sharing platforms.

Preparedness Resource Elements

P1: (Priority) Procedures in place to collect and handle antemortem data in a secure and confidential manner, including data collection and dissemination methods, for example the use of call centers, family reception centers, and family assistance centers, and relevant personnel functions, such as interviews with families to acquire antemortem data, data entry, and administrative activities.

(See Capability 6: Information Sharing)

P2: Procedures in place for family notification, depending upon public health agency fatality management lead or support role(s). Procedures may include

- Contacting and notifying family members
- Releasing information in coordination with the medical examiner's or coroner's office
- Managing family expectations for decedent identification, such as fingerprint or DNA identification
- Handling and release of decedents' personal effects

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Skills and Training Resource Elements

S/T1: Personnel trained, as necessary, to assist in the collection and dissemination of antemortem data. Training may include

- Courses covering the following topics
  - Providing relief to families after a mass fatality
  - Supporting roles identified by lead agency
  - Supporting family assistance and reception centers
- Courses offered by the National Transportation Safety Board (NTSB) Training Center, as necessary, which may include
  - Family Assistance (TDA301)
  - Advanced Skills in Disaster Family Assistance (TDA405)
  - Emergency Accounting for Victims Following Transportation Mass Casualty Incidents (TDA406)

Equipment and Technology Resource Elements

E/T1: Central repository or database for the collection, recording, and storage of antemortem and postmortem data.

E/T2: Technology to establish call centers or toll free numbers to collect and disseminate information.

Function 4: Support the provision of survivor mental/behavioral health services

Function Definition: Support the provision of non-intrusive and culturally sensitive mental/behavioral health services to incident survivors, family members of the deceased, and responders according to the jurisdictional public health agency role for fatality management in coordination with the jurisdictional fatality management lead authority and stakeholders.

Tasks

Task 1: Assemble trained mental/behavioral health team(s). Support the assembly of personnel and resources trained to provide mental/behavioral health services that are non-intrusive and culturally appropriate to accommodate the access and functional needs and religious or cultural practices of incident survivors, family members of the deceased, and responders.

Task 2: Support mental/behavioral health outreach services. Coordinate with stakeholders to support the provision of culturally appropriate mental/behavioral health services to incident survivors, family members of the deceased, and responders.

Preparedness Resource Elements

P1: (Priority) Procedures in place to identify, develop, and implement services for survivors, families, and responders in conjunction with jurisdictional mental/behavioral health partners. Procedures should reflect relevant cultural, religious, family, and burial practices.

(See Capability 1: Community Preparedness)

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P2: (Priority) Pre-identified personnel and resources to provide mental/behavioral health services to survivors and families. Personnel may include

- Public and private agencies including specialized agencies for mental health, children, and aging, as appropriate to assist with the organization and provision of services
- Spiritual care providers
- Translators
- Embassy and consulate representatives, when international victims are involved

Skills and Training Resource Elements

S/T1: Personnel trained in mental/behavioral health-related fatality management activities, such as supporting family assistance centers.

S/T2: Personnel with cultural competency training as related to fatality management.

Function 5: Support fatality processing and storage operations

Function Definition: Support activities to ensure that human remains, associated personal effects, and official documentation are safely and accurately recovered, processed, transported, tracked, recorded including death certificates, stored, and disposed of or released to authorized person(s) according to the jurisdictional public health agency role and fatality management procedures.

Tasks

Task 1: Support the safe management of human remains. Provide health protection and safety guidance to incident management or the jurisdictional lead authority to ensure the safe recovery, receipt, identification, transportation, storage, and disposition of human remains.

Task 2: Support timely and accurate investigations. Support forensic and other investigations, as requested, to assist with the identification of hazards, risks, and cause and manner of death.

Task 3: Conduct death reporting. Coordinate with partners to support near-real time electronic death reporting during the fatality management incident.

Task 4: Ensure death recording in official documentation. Coordinate with partners to facilitate accurate and timely collection and recording of mortality information for official death certificates.

Preparedness Resource Elements

P1: (Priority) Procedures in place for the jurisdictional public health agency to coordinate with partners and stakeholders in fatality processing and storage operations, including procedures to monitor the location of human remains and storage capacity.

P2: Procedures in place for timely electronic death reporting in medical examiner or coroner case management systems or electronic death registration systems for information sharing. Recommended data elements for electronic death reporting may include

- Incident details, including date, time, location, and situation
- Victim identification, including name, date of birth, gender, ethnicity, height, weight, address, social security number, and medical history

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- Victim relationships, such as identified family members and friends
- Location and types of injuries
- Cause of death (presumed, actual, or underlying)
- Death details, including date, time, location, and manner of death
- Circumstances that indicate whether the death was attributable to the event
- Human remains processing details
- Human remains storage location
- Health provider or responder details
- Survivor interview details
- Human remains disposition procedures

(See Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: Medical examiners, morticians, and other relevant personnel trained to conduct their identified role.

Equipment and Technology Resource Elements

E/T1: Materiel and equipment to process, store, and release human remains for final disposition. Materiel and equipment may include

- Portable x-ray unit
- Morgue equipment, such as storage trailers
- Medical instruments for autopsies
- Radiation survey equipment
- Portable autoclave
- Gloves, gowns, and other PPE
- Digital cameras
- Specimen containers and preservatives
- Refrigerated storage
- Computers and printers
- Death certificate special embossed paper

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Capability 6: Information Sharing

Definition: Information sharing is the ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness data among federal, state, local, tribal, and territorial levels of government and the private sector. This capability includes the routine sharing of information as well as issuing of public health alerts to all levels of government and the private sector in preparation for and in response to events or incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Identify stakeholders that should be incorporated into information flow and define information sharing needs
- **Function 2:** Identify and develop guidance, standards, and systems for information exchange
- **Function 3:** Exchange information to determine a common operating picture

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Emphasizes the need to implement data security and cybersecurity
- Emphasizes the need to decrease reporting time and increase collaboration by expanding use of electronic information systems, such as electronic death registration (EDR), electronic laboratory reporting (ELR), and syndromic surveillance systems)

For the purposes of Capability 6, partners and stakeholders may include the following:

- clinical and other professional organizations
- critical infrastructure services[2]
- emergency management agencies
- emergency response organizations[3]
- environmental health agencies
- federal, state, local, tribal, and territorial agencies
- food safety and agricultural representatives
- fusion centers
- hazardous material regulators and responders
- health care coalitions
- health care organizations
- health care providers
- health information exchanges
- immunization programs
- medical examiner or coroner offices
- mental/behavioral health agencies
- pharmacies
- private sector organizations
- public health agencies
- tribes and native-serving organizations

[2] For example, water and electrical utilities

[3] For example, law enforcement, fire departments, and emergency medical services (EMS)

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Function 1: Identify stakeholders that should be incorporated into information flow and define information sharing needs

Function Definition: Identify intra- and inter-jurisdictional stakeholders to participate in information exchange, and determine and periodically reassess stakeholders' needs for bi-directional information sharing.

Tasks

Task 1: Identify intra- and inter-jurisdictional stakeholders to incorporate into information flow. Identify intra- and inter-jurisdictional stakeholders to incorporate into information flow, and determine the information sharing needs for each stakeholder.

Task 2: Update and refine information sharing needs. Engage identified stakeholders regularly, and use quality improvement processes to continuously update and refine information sharing needs and capabilities.

Preparedness Resource Elements

P1: (Priority) Roster of identified stakeholders to engage for bi-directional information exchange across jurisdictional public health agencies and other partners and stakeholders.

P2: (Priority) Procedures in place to review and update the role-based public health directory that supports public health alert messaging. Recommended directory categories may include

- Organizational affiliation
- Assigned role(s) and notification tier
- Multiple sources of contact information, as available

(See Capability 4: Emergency Public Information and Warning)

P3: Established channels for stakeholder communications, such as standing meetings, electronic messaging, e-mailed communications, and web conferencing.

(See Capability 3: Emergency Operations Coordination and Capability 4: Emergency Public Information and Warning)

Equipment and Technology Resource Elements

E/T1: Information system(s) updated regularly and with appropriate backup to store and retrieve stakeholder contact information in a timely manner.

E/T2: System credentials and security clearances to access restricted information and systems, such as Epi-X, Homeland Security Information Network (HSIN), and the jurisdictional health alert network (HAN).

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Function 2: Identify and develop guidance, standards, and systems for information exchange

Function Definition: Define procedures and establish systems for information governance, management, and sharing.

Tasks

Task 1: Identify relevant data regulations, policies, and standards. Identify current jurisdictional and federal laws and policies that authorize, limit, or protect the exchange of information relevant to emergency situational awareness.

Task 2: Identify stakeholder data requirements. Coordinate with identified stakeholders to determine routine and incident-specific essential elements of information (EEI) for each stakeholder.

Task 3: Determine the conditions for information exchange. Identify when and to what extent information and data exchange is necessary for public health events and incidents.

Task 4: Develop systems for data storage and exchange. Identify and develop systems, such as electronic or non-electronic solutions to store, protect, control, and exchange data.

Task 5: Identify and mitigate barriers to information exchange. Use continuous quality improvement processes and corrective action systems to identify and mitigate procedural, legal, and policy-related barriers.

Preparedness Resource Elements

P1: (Priority) Procedures in place for information exchange that adhere to available national standards for health information exchange. Recommended standards and considerations may include

- Information exchange standards
  - Security levels, such as sensitive, but unclassified or confidential
  - Personnel authorized to share and receive information
  - Timeline and frequency
  - Data format, such as text or numeric and structure to ensure proper consumption in electronic health records (EHRs) and clinical decision support (CDS) systems
  - Data use and release parameters
  - Metadata needs
  - Data privacy and cybersecurity
  - Legal, statutory, and intellectual property regulations
- Other relevant considerations
  - Inventory Data Exchange (IDE) dependent upon medical countermeasure type
  - Electronic laboratory reporting (ELR), electronic case reporting (eCR), electronic death reporting (EDR), syndromic surveillance reporting, electronic laboratory test order and reporting (ETOR), immunization information systems (IIS), exchange of data among health jurisdictions, and data for other registries

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- Environmental exposures data including hazardous material releases, air monitoring, water quality samples, food contamination, and radiation detection Monitoring of individuals in isolation or quarantine and monitoring of populations for contamination
- Dissemination of clinical guidance for diagnostic evaluation and care
- Situational awareness briefings

(See Capability 9: Medical Materiel Management and Distribution and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P2: (Priority) Stakeholder-specific procedures, determinants, trigger events or other applicable criteria for health information exchange. Determinants may include

- Epidemiology/Surveillance
  - Unusual cluster(s) of illness that threaten closure of institutional settings, such as illness among health care workers or prisoners
  - Large numbers of patients with similar and unusual symptoms
  - Large number of unexplained deaths
  - High burden of illness or a cluster of illness confined to a specific population
  - Simultaneous clusters of similar illness in noncontiguous areas for example, because of travel to affected areas
  - Higher than expected morbidity and mortality associated with common symptoms or failure of patients to respond to traditional therapies
  - Incidents in other jurisdictions that raise possible risk in an individual's home jurisdiction including elevation of the pandemic influenza alert level
  - World Health Organization's (WHO's) Public Health Emergency of International Concern (PHEIC)
  - Laboratory
  - Diagnosis or clinical, laboratory, environmental, or pathology finding of public health concern
  - Public health laboratory findings not identified by clinical, surveillance, or epidemiological investigations, such as a novel virus
- Other
  - Illness or injury burden expected to overwhelm local health care or public health resources
  - Received threats or intelligence
  - Mass casualty incident due to a catastrophic event, such as flood, earthquake, terrorism, or industrial release

(See Capability 10: Medical Surge, Capability 12: Public Health Laboratory Testing, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P3: Procedures in place for data exchange in both routine and incident-specific settings, including agreed upon systems for data storage and exchange and data exchange frequency with CDC and other stakeholders, in accordance with jurisdictional standards.

P4: Strategies for collaboration and system integration to improve intra- and inter-jurisdictional information sharing for situational awareness during routine operations and public health events or incidents. Consider collaborative strategies and activities, which may include

- Increasing information system interoperability to support disease and syndromic surveillance, public health registries, outbreak management, exposure assessment, and other activities
- Extending data availability with dashboards and other information sharing tools

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P5: (Priority) Written agreements, such as contracts or memoranda of understanding (MOUs) with relevant agencies and other stakeholders to define participation, security or access levels, and procedures for information exchange.

P6: (Priority) Procedures in place to account for laws, provisions, and policies addressing privacy, security including cybersecurity, civil liberties, intellectual property, information sharing limitations, and other substantive issues. Relevant laws and policies may include

- Emergency powers for public health data collection and sharing
- Health Insurance Portability and Accountability Act (HIPAA)
- Office of the National Coordinator for Health Information Technology Policy
- U.S. Department of Health and Human Services (HHS) Information Management Policy
- State laws and regulations prohibiting information sharing to federal or inter-jurisdictional entities

P7: Guidelines for information exchange that requires security clearances, such as information exchange with the Federal Bureau of Investigation (FBI), state bureau of investigation, fusion centers, or agents with a "need to know."

Skills and Training Resource Elements

S/T1: Personnel with awareness-level training in pertinent laws and policies for information sharing procedures including transport of data and use of personally identifiable information (PII).

S/T2: Personnel trained in informatics and information technology project management, as necessary, to implement public health informatics systems.

Equipment and Technology Resource Elements

E/T1: Information systems that meet national data standards for interoperability as identified by CDC, other federal agencies, such as the Office of the National Coordinator for Health Information Technology, or other standards development organizations (SDOs). Recommended information system capabilities may include

- Receiving and transmitting data electronically using standards-based messaging
- Converting non-standard formats or terminologies into federally accepted standards for communication
- Receiving, using, and transmitting messages that adhere to certified EHR technologies or standards under Meaningful Use guidelines
- Transmitting and receiving data from non-electronic data sources, only if electronic capabilities are unavailable
- Gathering EEI or data from cross-disciplinary stakeholders and transmitting data into a public health situational awareness system

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Function 3: Exchange information to determine a common operating picture

Function Definition: Share information across public health agencies and intra- and inter-jurisdictional stakeholders using available national standards, such as data vocabulary, storage, transport, security, and accessibility standards.

Tasks

Task 1: Exchange health information. Exchange meaning request, send, and receive relevant data and information with identified cross-disciplinary stakeholders using procedures and systems that meet jurisdictional or federal standards.

Task 2: Maintain accessible data repositories. Support information exchange among cross-disciplinary stakeholders using accessible data repositories that adhere to jurisdictional or federal standards.

Task 3: Apply data security protocols. Request, send, and receive information using security protocols that meet jurisdictional or federal standards.

Task 4: Verify data authenticity. Confirm data authenticity with message sender or information requestor.

Task 5: Acknowledge receipt of information. Confirm the successful transmission and receipt of information, as appropriate, for the incident.

Preparedness Resource Elements

P1: (Priority) Procedures in place to develop information and public health alert messages. Procedures may include

- Time sensitivity of information
- Relevance to public health
- Target audience
- Security level or sensitivity of information
- Actions required following the receipt of information, such as sending a response

(See Capability 4: Emergency Public Information and Warning)

P2: (Priority) Procedures in place for information exchange with fusion centers and other intelligence entities. Procedures may include

- Defined intelligence requirements that prioritize and guide planning, collection, analysis, and information dissemination efforts
- Delineated roles, responsibilities, and requirements for each level and sector of government

P3: (Priority) Procedures in place for information exchange among jurisdictional health care entities using electronic public health case-reporting systems, syndromic surveillance systems, notifiable disease surveillance systems, electronic death registration systems, immunization information systems, or other specialized registries. Data should be shared using electronic systems when available or as possible. Electronic information sharing may include

- Sharing reportable diagnoses and related information from a health information exchange (HIE) or an EHR system to state and local public health agencies

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- Sharing laboratory test results from commercial, public health, hospital, and other laboratories' laboratory information management system (LIMS) to state and local public health agencies
- Sharing laboratory test orders and results between a public health laboratory and another laboratory or a clinical setting
- Sharing immunization information between an HIE or EHR system and public health immunization registries, public health syndromic surveillance systems, such as CDC's National Syndromic Surveillance Program BioSense Platform, or other public health registries
- Sharing notifiable disease data among public health agencies and between public health agencies and CDC
- Sharing information regarding individuals undergoing health monitoring or in isolation and quarantine

P4: Procedures in place to acknowledge receipt by trusted sources and send verification of information to intended audience(s).

P5: Templates for public health alert messages and procedures including distribution methods to ensure messages reach intended individuals 24/7 year-round. Public health alert message templates may include

- Subject or title
- Description
- Background
- Request or recommendations (if action requested)
- Recipient(s)
- Point of contact to address additional questions
- Links to additional information

(See Capability 4: Emergency Public Information and Warning)

P6: Information Sharing and Access Agreements (ISAA) or similar agreements with data sharing partners. Recommended elements for ISAAs may include

- Breach notification procedures, particularly if data is not stored in an encrypted state
- Maintenance of HIPAA Security Rule compliance, when potential PII must be shared

Skills and Training Resource Elements

S/T1: Personnel, such as informaticians trained on public health information systems to develop, sustain, coordinate, and oversee public health informatics.

S/T2: Information system support personnel trained, as necessary, to maintain or enhance the functionality and capacity of public health information systems, perform public health information specialist and informatics roles, and use data standards and facilitate interoperability across allied disciplines, including the Open Geospatial Consortium.

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Equipment and Technology Resource Elements

E/T1: (Priority) Electronic systems for routine information transmission, emergency notification, and situational awareness between health care and public health systems and between jurisdiction-based surveillance systems and CDC that meet applicable national and jurisdictional standards. Standards may include

- Data format and structure
- System interoperability
- Data quality and reliability
- Consent, security, and privacy for protected health information and other sensitive information, as applicable, such as protections against data breaches using encryption
- Data governance or ownership and rules or agreements for data use, reuse, release, and publication
- Controls and safeguards for data storage and access that may include
  - Authentication service for data requests and submissions from various locations
  - System administrator password policies
  - Updated security patches
  - Encryption, as required

(See Capability 3: Emergency Operations Coordination and Capability 13: Public Health Surveillance and Epidemiological Investigation)

E/T2: Systems that automate transmission of information from the clinical setting, such as an EHR system, to the public health agency in compliance with jurisdiction-specific reporting regulations to support overall public health surveillance, improve the timeliness and accuracy of data submitted to state and local public health agencies, and enable subsequent information sharing with CDC.

E/T3: (Priority) Secondary systems for information sharing and public health alerting in the event that the primary system is unavailable.

(See Capability 4: Emergency Public Information and Warning)

E/T4: Data visualization tools, such as analytic dashboards and geographic information systems (GIS) for effective presentation and dissemination of data for situational awareness in routine and response situations.

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Capability 7: Mass Care

Definition: Mass care is the ability of public health agencies to coordinate with and support partner agencies to address within a congregate location (excluding shelter-in-place locations) the public health, health care, mental/behavioral health, and human services needs of those impacted by an incident. This capability includes coordinating ongoing surveillance and assessments to ensure that health needs continue to be met as the incident evolves.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Determine public health role in mass care operations
- **Function 2:** Determine mass care health needs of the impacted population
- **Function 3:** Coordinate public health, health care, and mental/behavioral health services
- **Function 4:** Monitor mass care population health

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates content for accommodating individuals with functional and access needs within general population shelters
- Includes considerations for registration of individuals requiring decontamination or medical tracking in the event of an environmental health incident
- Coordinated content with the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Preparedness and Response's (ASPR) Health Care Preparedness and Response Capabilities

For the purposes of Capability 7, partners and stakeholders may include the following:

- agricultural departments
- animal control[4]
- designated safety officers
- emergency management agencies[5]
- emergency medical services (EMS)
- fire departments
- HazMat authorities
- health care coalitions
- health care organizations
- human services organizations and providers
- human services providers
- humane societies
- law enforcement agencies
- organizations that can provide or support mass care services[6]
- public health agencies
- radiation control authorities
- social services
- state hospital associations
- tribes and native-serving organizations

[4] For example, Board of Animal Health and National Veterinarian Response teams

[5] For example, the Federal Emergency Management Agency (FEMA)

[6] For example, the American Red Cross and other voluntary organizations active in disasters (VOADs)

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Function 1: Determine public health role in mass care operations

Function Definition: In coordination with Emergency Support Functions (ESFs) #6, #8, and #11 partners and stakeholders, define the public health roles and responsibilities in supporting mass care operations.

Tasks

Task 1: Identify the public health agency role in mass care operations. Determine mass care roles and responsibilities of the jurisdictional public health agency as a lead or support agency when working with collaborating organizations. Address the access and functional needs of at-risk individuals.

Task 2: Operationalize the public health agency mass care role. Coordinate with ESF #6, #8, and #11 partners to conduct infectious disease surveillance and environmental health and safety assessments, provide support for addressing the access and functional needs of at-risk individuals, and support decontamination to assist in a mass care response.

Preparedness Resource Elements

P1: (Priority) Procedures in place to coordinate with ESF #6, #8, and #11 partners, including emergency management, environmental health, and other agencies, to identify the jurisdictional public health agency lead or support role(s) for mass care. Public health agency roles and responsibilities may include

- Supporting the delivery of health care by jurisdictional partners
- Providing access to mental/behavioral health services
- Coordinating logistics for mass sheltering with the Incident Command System and other responsible entities
- Providing access to human services and other support to individuals with access and functional needs
- Conducting and reporting on human health surveillance, including investigating contagious diseases transmitted between animals and people
- Providing access to medications needed for pre-existing conditions as well as medical countermeasures, including immunization services, if appropriate, for populations being sheltered
- Overseeing environmental health and safety, to include hygiene procedures, sanitation management procedures, and food and facility safety inspections
- Providing radiological, nuclear, biological, and chemical screening and decontamination services
- Providing sanitation and waste removal, including working with entities regulating medical waste
- Providing shelter and care for service animals and pets

P2: Written agreements, such as contracts or memoranda of understanding (MOUs) with partner agencies to support the access and functional needs of at-risk populations. Accommodations for populations with access and functional needs may include

- Individual assistive services, equipment, and care, such as occupational therapy, family caregivers, and assistive technology
- Placement of individuals with disabilities and others with access and functional needs in the least restrictive environment possible
- Social services

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- Use of universal design principles in signage and accessibility
- Language translators and sign language interpreters

(See Capability 1: Community Preparedness)

P3: Procedures in place to disseminate situational awareness information to jurisdictional emergency management agencies and to alert partner organizations during a response requiring mass care services based on the jurisdictional public health agency lead or support role. Recommended procedures for notification and information sharing may include

- Contact information of at least one representative from each organization
- Procedures to ensure communication will work properly during an emergency, including regularly updating contact lists and conducting notification drills
- Procedures for using redundant communications systems, such as health communication systems, cell phones, texting, satellite phones, radios, and WebEOC to be used across organizations and health care systems and within operational areas
- Methods for sending health alerts, including e-mail, text, or automated notice
- Methods for confirming receipt of health alerts
- Process for organizations to confirm their participation in the mass care response

(See Capability 3: Emergency Operations Coordination, Capability 6: Information Sharing, Capability 8: Medical Countermeasure Dispensing and Administration, Capability 11: Nonpharmaceutical Interventions, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

Function 2: Determine mass care health needs of the impacted population

Function Definition: Determine the public health, health care, human services, and mental/behavioral health needs of those impacted by the incident in coordination with ESF #6, #8, and #11 partners, emergency management agencies, and other partner agencies.

Tasks

Task 1: Identify population health needs of impacted areas. Coordinate with response partners to identify population health needs in the area impacted by the incident using existing jurisdictional risk assessments; data on biological, chemical, or radiological hazards in the area; other environmental data; and health demographic data.

Task 2: Assess congregate locations. Coordinate with response partners to complete facility-specific environmental health and safety assessments of the pre-selected congregate locations.

Task 3: Ensure food and water safety at congregate locations. Coordinate with partner agencies as necessary to conduct food and water safety inspections at congregate locations.

Task 4: Ensure health screening and identification of access and functional needs. Coordinate with response partners to conduct health screenings and identify medical, access, and functional needs such as needs related to communication, maintaining health, independence, support, safety, self-determination, and transportation (CMIST) (as defined in the CMIST framework), of the population registering at congregate locations.

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Preparedness Resource Elements

P1: (Priority) Procedures in place and assessment criteria to be used for environmental health assessments and inspections of shelters.

Recommended elements of the shelter assessment procedures may include

- Contact information and process for contacting the lead shelter operation organization
- Public health presence in shelter decision-making entity or command center
- Equipment needed for the assessment, such as radiation detection devices
- Order of operations for assessment, including activities for prior-to-entry and post-entry
- Corrective action time frames
- Repeat assessments (initial assessment should occur within 48 hours after a site opens)

Recommended criteria for shelter inspection may include

- Absence of barriers that restrict access for people with disabilities and others with access and functional needs
- Infrastructure redundancy, including backup power (generator) and communications equipment
- Absence of contamination, such as radiological, nuclear, biological, or chemical
- Adequate sanitation including toilets, showers, hand washing stations, and other accommodations, and waste removal including for sheltered animals
- Potable water supply
- Adequate ventilation and climate control
- Clean and appropriate location for food preparation and storage
- Absence of pests or vectors
- Separation of medical facility and general living area for privacy, confidentiality, and isolation of infectious disease
- General facility safety, including structural integrity, stairs with handrails, step-downs, and the absence of slick floors, exposed wiring, or other potential facility hazards

P2: (Priority) List of pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as congregate locations in accordance with jurisdictional strategies for emergency operations sheltering based on the size, scope, and impact of potential incidents estimated from jurisdictional risk assessments.

(See Capability 1: Community Preparedness)

P3: Procedures in place to adopt or amend jurisdictional restaurant or food service requirements for food and water assessments at shelters or procedures for coordinating assessments of food sources. Procedures may include

- Identifying and assessing general safety issues
- Ensuring food safety including proper storage, handling, and tracking
- Ensuring safety of potable water
- Assessing housekeeping, cleaning, and sanitation
- Ensuring proper management of wastewater and solid waste
- Ensuring that personal hygiene amenities, such as soap, hot water, and hand sanitizer are provided
- Ensuring hygiene education is provided to clients, response partners, and volunteers handling food

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- Ensuring air quality control
- Identifying and assisting with vector or pest control issues
- Assessing safety and sanitation of childcare
- Coordinating with partners, if appropriate, to ensure personnel safety and security

P4: Procedures in place for how the public health agency, based on the jurisdictional public health agency mass care role, will coordinate with partners and stakeholders to provide specialty food items that address the nutritional needs or requirements of young children, pregnant or postpartum women and infants, older adults, and individuals with access and functional needs, such as communication, maintaining health, independence, services and support, and transportation needs (CMIST framework).

(See Capability 13: Public Health Surveillance and Epidemiological Investigation)

P5: Procedures in place to refer individuals to health services from the congregate location, medical facilities, specialized shelters, or other sites. Recommendations include coordinating with organizations assigned as responsible for transfer, such as EMS or medical transport providers, and reviewing emergency transportation strategies with jurisdictional transportation agencies.

(See Capability 6: Information Sharing and Capability 10: Medical Surge)

Skills and Training Resource Elements

S/T1: Access to personnel skilled in the use of and able to access geographical information systems (GIS) or other mapping systems.

S/T2: Personnel trained in conducting environmental health and safety assessments in shelters. Recommended trainings and tools may include

- Environmental Health Training in Emergency Response (EHTER)
- Environmental Health Shelter Assessment Tool
- Council of State and Territorial Epidemiologists (CSTE) Disaster Epidemiology Tool Repository

S/T3: Shelter registration personnel or health professionals trained to recognize the need to refer individuals to health services, specialized shelters, or medical facilities, as appropriate.

S/T4: Personnel trained in chemical, biological, and radiological decontamination.

(See Capability 12: Public Health Laboratory Testing)

Equipment and Technology Resource Elements

E/T1: (Priority): Tools and materials for health screening of individuals during shelter registration. Health screening questions may include

- Immediate medical needs
- Durable medical equipment (DME) and assistive technology needs
- Mental/behavioral health needs
- Immunization history
- Sensory deficits or other disability
- Medication use
- Need for assistance with activities of daily living
- Substance abuse

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E/T2: Access to GIS or other system, such as zip code sorting to identify the location of at-risk individuals with access and functional needs that may be disproportionately impacted, including individuals with limited English proficiency, refugees, individuals with low income, people with chronic conditions, people with disabilities, and people living in long-term care within the jurisdiction and to compare their locations to pre-identified shelter locations and incident impact areas.

E/T3: Access to decontamination shelters and facilities and personnel trained on their use based on the type of shelter and facilities to be used.

Function 3: Coordinate public health, health care, and mental/behavioral health services

Function Definition: Coordinate with partner and stakeholder agencies to provide access to health care, mental/behavioral health, and human services; medication, immunization, and consumable medical supplies, such as hearing aid batteries and incontinence supplies; DME for the impacted population; and specialized support to address the access and functional needs of individuals who may be disproportionately impacted by the incident.

Tasks

Task 1: Ensure accessibility of health care and mental/behavioral health services. Coordinate with health care partners and other applicable providers to ensure health care, mental/behavioral health, and human services; medication, immunizations, and consumable medical supplies, such as hearing aid batteries and incontinence supplies; and DME are provided at or through congregate locations based on mass care needs.

Task 2: Support at-risk individuals with access and functional needs impacted by the incident. Coordinate with applicable providers to integrate the delivery of human services and necessary medication and devices that address the access and functional needs of at-risk individuals disproportionately impacted by the incident or event.

Task 3: Support population monitoring and decontamination services. Coordinate with jurisdictional partners, such as lead HazMat authority or other agencies to establish tracking systems and support the decontamination of contaminated or possibly contaminated, including radiological, nuclear, biological, or chemical contaminants, individuals who may enter congregate locations.

Task 4: Provide culturally and linguistically appropriate information. Disseminate and promote accessible and culturally and linguistically appropriate information regarding mass care health services to the public.

Task 5: Coordinate care for service animals. Coordinate with agencies to accommodate and provide care for service animals, including veterinary care, essential needs, and decontamination, within general shelter populations.

Task 6: Coordinate care for household pets. Collaborate with partner agencies to coordinate the location of human sheltering efforts with household pet sheltering efforts.

Task 7: Return displaced individuals to pre-incident medical environments. Coordinate with partners and stakeholders to return individuals displaced by the incident to their pre-incident medical environments, such as prior medical care provider, skilled nursing facility, or place of residence.

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Preparedness Resource Elements

P1: (Priority) Written agreements, such as contracts or MOUs with organizations that support the provision of medication and administration of vaccines. Recommended provisions for agreements may include

- Requesting medication and vaccines from providers (circulating inventories or cached supplies)
- Bringing medication and vaccines to congregate locations
- Securing, storing, and distributing medication and vaccines at congregate locations
- Referring and transporting individuals to pharmacies and other providers for medication or vaccine
- Enrolling of pharmacies in the Emergency Prescription Assistance Program (EPAP)

(See Capability 8: Medical Countermeasure Dispensing and Administration, Capability 9: Medical Materiel Management and Distribution, and Capability 10: Medical Surge)

P2: (Priority) Scalable congregate location staffing models for health services, based on the incident, number of impacted individuals, resources available, competing priorities, and time frames in which interventions should occur. Staffing models may address needs and activities, which may include

- Addressing barriers that restrict individuals with disabilities and access and functional needs, as defined in the CMIST framework
- Integrating mental/behavioral health services
- Assessing environmental health standards, such as food, water, and sanitation
- Collecting, monitoring, and analyzing aggregate data
- Integrating immunization services
- Providing infection control practices and procedures
- Using data sharing agreements, such as with the American Red Cross
- Providing risk management and risk communication services to all sheltered individuals, if needed, especially if the incident involves chemical, biological, or radiological hazards

(See Capability 1: Community Preparedness and Capability 10: Medical Surge)

P3: (Priority) General population shelters that accommodate families with children, persons with disabilities, and those with access and functional needs and have procedures to transfer individuals from general shelters to specialized shelters or medical facilities. Recommended procedures for transfers may include

- Procedures to coordinate with medical and non-medical transportation partners
- Procedures for information transfer, such as age, sex, current condition, vital signs (if available), chief complaint, differential diagnosis, relevant medical history, medical supplies, and DME needs
- Procedures for physical transfer of patient and caregiver, if appropriate, to specialized shelters or medical facilities
- Procedures for tracking items transferred with the patient, such as medications, personal medical equipment, identification, and personal items
- Procedures and designated facilities to support isolation and quarantine, including transportation to proper isolation for patients with potential or confirmed exposure to certain biological agents

(See Capability 8: Medical Countermeasure Dispensing and Administration, Capability 9: Medical Materiel Management and Distribution, Capability 10: Medical Surge, and Capability 11: Nonpharmaceutical Interventions)

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P4: (Priority) Written agreements, such as contracts or MOUs with partner and stakeholder agencies to monitor populations at congregate locations. These agreements may include

- Assistance with registering, as necessary, injured, exposed, or potentially exposed individuals for long-term health monitoring, including the use of rapid response registries and immunization information systems (IIS)
- Support for establishing separate shelter facilities for monitoring individuals at congregate locations
- Assistance with identifying, stabilizing, and referring individuals requiring immediate health care or decontamination
- Identification of designated facilities to support isolation and quarantine, including transportation to proper isolation for patients with potential or confirmed exposure to certain biological agents

(See Capability 3: Emergency Operations Coordination)

P5: (Priority) Scalable congregate location staffing matrices for radiation incidents that identify each population monitoring and decontamination response role. Roles may include

- Managing a population monitoring operation, such as leading overall Community Reception Center (CRC) operations
- Monitoring those arriving for external contamination and assessing exposure risk
- Supporting decontamination
- Assessing physical exposure and internal contamination

P6: Written agreements, such as contracts or MOUs with medical supply and medical equipment providers to support medical logistics. Agreements may include

- Processes to bring supplies and equipment to the congregate locations
- Processes for accountability of equipment during the mass care response
- Processes to return equipment to providers when no longer needed

(See Capability 9: Medical Materiel Management)

P7: Procedures in place to coordinate with response partners responsible for decontamination of individuals at congregate locations, if necessary. Procedures may include

- Identification of organizations trained in decontamination
- Establishment of decontamination stations, including stations accessible to individuals with access and functional needs
- Delivery of decontamination supplies, such as shower supplies, personal protective equipment (PPE), plastic bags to collect possibly contaminated material, and medical supplies
- Delivery of medical countermeasures for treatment
- Removal and security of stored contaminated materials away from congregate location populations

(See Capability 8: Medical Countermeasure Dispensing and Administration, Capability 9: Medical Materiel Management and Distribution, and Capability 11: Nonpharmaceutical Interventions)

P8: Procedures in place to account for sheltering and care for service animals and household pets at congregate locations.

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Recommended procedures may include

- Pre-identified locations that can serve as temporary shelters for small and large pets and service animals
- Procedures to ensure non-discrimination for people with disabilities, including those with a service animal
- Pre-established contracts for decontamination and provision of food, water, bedding supply, and other equipment needed for designated animal shelter locations and service animals in congregate locations
- Procedures to coordinate animal medical evaluations for injuries, hazardous material exposure, diseases, and other animal health issues
- Tracking or follow-up mechanism for hazardous material exposures
- Process for the quarantine of animals
- Pre-arranged jurisdictional veterinary support from veterinary teaching hospitals, jurisdictional animal response teams, animal day care centers, and other partners via contracts or other mechanisms
- Processes and identified personnel to conduct service animal or pet decontamination at congregate locations, including washing stations for owners to conduct animal decontamination

Skills and Training Resource Elements

S/T1: Personnel trained to use PPE for all hazards, including infection control, chemical safety, and radiation safety, including management of potentially exposed persons, decontamination, and dosimetry.

S/T2: Personnel that will be involved with animal care services trained as needed. Recommended trainings may include

- Federal Emergency Management Agency (FEMA) Animals in Disaster
  - Module A: Awareness and Preparedness (IS-10)
  - Module B: Community Planning (IS-11)

(See Capability 10: Medical Surge and Capability 15: Volunteer Management)

Function 4: Monitor mass care population health

Function Definition: Monitor ongoing health-related mass care support and ensure health needs continue to be met as the incident response evolves.

Tasks

Task 1: Monitor environmental health and safety at congregate locations. Conduct facility-specific environmental health and safety monitoring in coordination with partner agencies, including screening for contamination, such as radiological, nuclear, biological, or chemical contamination, and correct any identified deficiencies.

Task 2: Conduct health surveillance at congregate locations. Identify cases of illness, injury, immunization status, and exposure within mass care populations.

Task 3: Provide situational awareness of health needs at congregate locations. Identify ongoing and changing health needs as part of public health agency or jurisdictional situational awareness reports, share information with the incident management system, and request additional federal, regional, state, local, tribal, and territorial assistance.

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Task 4: Demobilize mass care operations. Create and execute a health resource demobilization plan in conjunction with partner and stakeholder organizations to de-escalate the response as appropriate to the incident.

Preparedness Resource Elements

P1: (Priority) Procedures in place to conduct ongoing shelter population health surveillance. These procedures may include

- Identification or development of mass care surveillance forms and processes
- Thresholds for when to begin surveillance activities
- Procedures for contacting public health representatives in case of an emergency, such as an outbreak
- Procedures, trainings, and resources to support the use of IIS on site to assess immunization status and document immunizations administered
- Coordination of health surveillance with partner and stakeholder organizations

(See Capability 13: Public Health Surveillance and Epidemiological Investigation and Capability 15: Volunteer Management)

P2: (Priority) Templates for disaster-surveillance forms, including active surveillance and facility 24-hour report forms.

P3: Procedures in place for demobilization operations, which may include

- Processes to inform responding agencies of demobilization of health services
- Responsibilities or agreements for reconditioning and return of equipment when no longer needed
- Time frame for ending mass care health services upon shelter closure notice

(See Capability 3: Emergency Operations Coordination and Capability 10: Medical Surge)

Equipment and Technology Resource Elements

E/T1: Electronic database or other data storage system to document, at a minimum, the number and type of health needs addressed and disposition, such as whether the individual was hospitalized or sent home, of individuals using mass care health services.

E/T2: Registration systems for individuals requiring decontamination or medical tracking.

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Capability 8: Medical Countermeasure Dispensing and Administration

Definition: Medical countermeasure dispensing and administration is the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident. This capability focuses on dispensing and administering medical countermeasures, such as vaccines, antiviral drugs, antibiotics, and antitoxins.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Determine medical countermeasure dispensing/administration strategies
- **Function 2:** Receive medical countermeasures to be dispensed/administered
- **Function 3:** Activate medical countermeasure dispensing/administration operations
- **Function 4:** Dispense/administer medical countermeasures to targeted population(s)
- **Function 5:** Report adverse events

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Revises the Capability 8 title, definition, and content to account for both the dispensing and the administration of medical countermeasures, such as vaccines, antidotes, and antitoxins
- Adds content and resources to account for potential radiological or nuclear exposure
- Broadens the network of dispensing and administration sites to include pharmacies and other locations

For the purposes of Capability 8, partners and stakeholders may include the following:

- emergency management agencies
- emergency medical services (EMS)
- environmental health agencies
- epidemiology programs
- federal groups and organizations
- government agencies
- health care coalitions
- health care organizations
- hospitals and health care facilities
- immunization programs
- jurisdictional office(s) of homeland security
- laboratory programs
- law enforcement agencies
- medical professional organizations
- mental/behavioral health services
- military installations and other federal facilities
- organizations representing persons with disabilities or persons requiring specialized access and functional accommodations
- pharmacies
- private organizations that may function as dispensing or vaccination sites
- public health agencies
- Public Health Service Commissioned Corps
- radiation control programs
- surveillance programs
- tribes and native-serving organizations
- volunteer groups

[7] For example, the U.S. Department of Health and Human Services regional emergency coordinators (RECs) and medical countermeasure specialists

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Function 1: Determine medical countermeasure dispensing/administration strategies

Function Definition: Coordinate with partners to formulate jurisdiction-specific strategies for the timely provision of medical countermeasures based on incident needs.

Tasks

Task 1: Develop jurisdiction-specific strategies to prepare for medical countermeasure dispensing/administration. Coordinate with subject matter experts, partners, and stakeholders to develop strategies to dispense/administer medical countermeasures based on jurisdiction-specific risks, resource availability, and incident characteristics. Strategies should consider allocation methods for scarce resource scenarios.

Task 2: Establish a network of dispensing/administration sites. Identify dispensing/administration sites to activate when responding to a public health incident.

Task 3: Identify and assign required response roles. Identify and assign necessary medical countermeasure response roles and responsibilities in coordination with partners and stakeholders.

Preparedness Resource Elements

P1: (Priority) Multidisciplinary planning group(s), consisting of subject matter experts and key partners, to formulate and confirm medical countermeasure dispensing/administration strategies and roles.

(See Capability 1: Community Preparedness)

P2: (Priority) Procedures in place to identify medical countermeasures required to respond to current or projected incidents. Medical countermeasure needs may be determined by analyzing factors, which may include

- Number(s), location(s), and demographic information of people affected by the incident
- Types of available medical countermeasures
- Supplies and services necessary for individuals with access and functional needs
- Agent or cause of the incident
- Severity of the incident
- Projected timeline for establishing medical countermeasure dispensing/administration operations
- Pre-established activation triggers, indicators, and thresholds
- Types and numbers of personnel needed to provide medical countermeasures
- Types and numbers of dispensing/administration sites needed to provide medical countermeasures, whether a network of points of dispensing (PODs) or a network of vaccination sites in the community
- Federal or jurisdictional guidance for the prioritization of medical countermeasures, such as guidance for allocating vaccine to provider sites and patients during an influenza disease outbreak

(See Capability 3: Emergency Operations Coordination, Capability 9: Medical Materiel Management and Distribution, Capability 12: Public Health Laboratory Testing, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

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P3: (Priority) Procedures in place to guide the dispensing/administration of medical countermeasures. Procedures may include

- Screening protocols to ensure an individual receives the appropriate medical countermeasures according to priority or target group status specific to the incident
- Procedures for pre-event and just-in-time event rapid enrollment, ordering and receiving, administration, documentation of medical countermeasures and vaccines dispensed/administered for a range of provider types and settings in public and private sectors
- Protocols to assure informed consent and communication of risks and benefits as outlined in emergency use authorization (EUA) or emergency use instructions (EUI)
- Protocols to track the interval between a first and second dose in cases when this information is necessary
- Procedures to communicate when subsequent doses are due, such as text message, e-mail, or other reminder or recall methods
- Medical countermeasure logistics and storage to maintain product integrity during the dispensing/administration process
- Security protocols to ensure facility safety, personnel safety, product security, and crowd management
- Protocols for use of medical countermeasures in cases when decontamination is needed, such as after chemical or radiological exposures
- Protocols for the disposition of unused medical countermeasures and potentially infectious waste
- Methods for documenting medical countermeasures dispensed/administered, such as immunization information systems (IISs) for vaccines, and procedures for training and on-boarding new providers on use of these information systems
- Strategies for providing medical countermeasures to critical workforce, health care providers, and public health responders to meet the needs of the incident, such as personal protective equipment (PPE), ventilators, vaccines or other medicines
- Multiple strategies to ensure access to medical countermeasures, such as direct contact with affected individuals or hotline contacts
- Contact information of key personnel assigned and trained to fill emergency response roles when medical countermeasures are dispensed/administered
- Strategies for providing medical countermeasures to households of critical workforce, if indicated as directed by the U.S. Government

P4: (Priority) Network of sites for dispensing/administering medical countermeasures. Sites may include points of dispensing (PODs), vaccination clinics, pharmacies, hospitals, health care facilities, school clinics, or temporary mass vaccination sites. Considerations for a network of sites may include

- Written agreements to share resources, facilities, services, and other potential support required when dispensing/administering medical countermeasures, such as contracts or memoranda of understanding (MOUs)
- Comprehensive list of public and private sector medical countermeasure dispensing/administration sites that includes addresses, phone numbers, and e-mail addresses
- Site-specific standard operating procedures and staffing plans for medical countermeasure dispensing/administration, such as processes to order and receive medical countermeasures, personnel training(s), and use of jurisdictional inventory management systems and immunization information systems

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- Existing infrastructure and resources that may be available for use, such as the network of vaccine administration sites supported by the Vaccines for Children program or mail order pharmacy systems
- Alternate approaches for reaching tribal populations, including cross-jurisdictional agreements
- Alternate approaches for populations that may be difficult to reach, such as individuals who are undocumented, incarcerated, or experiencing homelessness and individuals who reside in long-term care or other congregate care facilities
- Alternate approaches for providing effective communication in multiple formats to account for the access and functional needs of at-risk individuals who may be disproportionately impacted by a public health incident or event, including children, pregnant women, older adults, and others with access and functional needs as well as communities that may be disproportionately impacted by a public health emergency
- Alternate approaches for providing medical countermeasures, such as direct to patient or home delivery
- Methods to track and monitor countermeasures dispensed, administered, or used across the network of sites

The selection of dispensing/administration sites should be adapted to the incident, and sites may include

- Open or closed PODs
- Vaccination clinics
- Hospitals, primary care, or other health care facilities
- Chain and independent pharmacies
- Public or private facilities
- Community or faith-based organization facilities
- Federal facilities, such as Department of Defense and Veterans Affairs facilities, as applicable
- School-based sites
- Workplace sites or occupational health clinics
- Temporary mass vaccination sites
- Doctor offices and other outpatient facilities

Skills and Training Resource Elements

S/T1: Personnel trained to dispense/administer medical countermeasures. Personnel considerations may include

- Requirements for licensing or certifying personnel providing medical countermeasures as determined by the jurisdiction
- Training to manage a potentially diffused network of dispensing/administration sites, such as vaccine administration through community pharmacies
- Necessary credentialing or background checks to assure personnel qualifications
- Training to ensure operational competence and familiarity with jurisdictional incident command structure
- Training to ensure adherence to clinical dispensing/administration protocols
- Training to communicate with and support those with access and functional needs, such as sign language interpreters

(See Capability 3: Emergency Operations Coordination , Capability 9: Medical Materiel Management, and Capability 15: Volunteer Management)

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S/T2: Personnel trained to conduct tabletop, functional, and full-scale exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP) in order to test and evaluate jurisdictional medical countermeasure strategies.

Function 2: Receive medical countermeasures to be dispensed/administered

Function Definition: Request and receive medical countermeasures at the jurisdictional level and ensure receipt of medical countermeasures at dispensing/administration sites based on incident characteristics.

Tasks

Task 1: Evaluate jurisdictional medical countermeasure inventories. Assess the ability of jurisdictional medical countermeasure inventories to meet the jurisdiction's needs based on the incident.

Task 2: Request medical countermeasures. Request or obtain medical countermeasures using established procedures from federal, jurisdictional, or private partners and stakeholders to meet supply needs.

Task 3: Receive medical countermeasures at dispensing/administration sites. Ensure all activated medical countermeasure dispensing/administration sites receive apportioned inventories according to incident requirements, logistics, infrastructure, and security strategies.

Preparedness Resource Elements

P1: (Priority) Procedures in place to assess medical countermeasure inventories and determine the need for additional medical countermeasures. Procedures to assess supply inventories may include

- Initial assessment of jurisdictional medical countermeasure inventories and supporting infrastructure prior to requesting mutual aid or federal assistance
- Inventory assessment and management throughout the incident response, for example, tracking inventory use and redeploying inventory to accommodate surges caused from under or overutilization of medical countermeasure dispensing/administration sites
- Assessments and procedures to identify and maintain ancillary medical countermeasure supplies

(See Capability 9: Medical Materiel Management and Distribution)

P2: (Priority) Procedures in place to request, order, and receive medical countermeasures at dispensing/administration sites, as applicable, in accordance with guidelines provided by the supply source, including the Strategic National Stockpile (SNS), jurisdictional immunization programs receiving vaccine from Biomedical Advanced Research and Development Authority (BARDA), or other applicable sources. These procedures should facilitate

- Assessment of local inventories and medical countermeasure caches to determine initial supply or resupply needs
- Identification of local pharmaceutical and medical supply wholesalers
- Decision tree to guide the process for requesting or ordering additional medical countermeasures and account for the status of emergency declarations
- Adherence to regulatory standards required for maintaining jurisdictional medical countermeasure caches, such as U.S. Food and Drug Administration (FDA) standards, including current good

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manufacturing practices, appropriate Drug Enforcement Administration (DEA) registrations, and the ability to track medical countermeasures rotation

P3: (Priority) Procedures in place for the storage and handling of medical countermeasures at dispensing/administration sites. Procedures may include

- Procedures for cold chain management
- Procedures to properly store and package unit-of-use doses according to pharmacy laws and manufacturer specifications
- Procedures for freeze-dried vaccine that must be reconstituted with a diluent
- Procedures to outline requirements for receiving vaccines when jurisdictional vaccine provider agreements are in place, such as the Vaccines for Children program
- Procedures to legally accept and manage controlled substances, including registration with the DEA
- Procedures to consider and incorporate other specific medical countermeasure dispensing/administration storage and handling needs

Equipment and Technology Resource Elements

E/T1: Information system(s) to track the medical countermeasures dispensed or administered for the purposes of informing resupply requests, understanding populations reached, and monitoring adverse events. Information systems may operate independently of the jurisdiction's inventory management system or be electronically networked to the system. Elements to track in information systems may include

- Targeted population(s)
- Name of the drug, generic or brand, or vaccine
- National Drug Code (NDC) number
- Lot number
- Expiration/manufacturing dates
- Site where medical countermeasure was dispensed/administered
- Inventory balance
- Interval between doses of a vaccine

E/T2: Equipment, supplies, and systems needed to support dispensing/administration, which may include

- Materiel-handling equipment, such as pallet jacks, handcarts or dollies, scissor-lifts, and forklifts
- Primary and backup cold chain management equipment, such as portable, insulated containers for transporting temperature-sensitive medical countermeasures, refrigerators, thermometers, and other equipment needed to meet storage and handling requirements
- Ancillary medical supplies and durable medical equipment
- Infrastructure supplies and systems, such as paper supplies, copiers, computers, printers, Internet/network access to support site inventory management, white boards, desks, vests, line tape, signage, and consent forms

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Function 3: Activate medical countermeasure dispensing/administration operations

Function Definition: Coordinate with partners and stakeholders to ensure resources, including personnel, equipment, technology, and physical space, are activated to dispense/administer medical countermeasures.

Tasks

Task 1: Activate medical countermeasure dispensing/administration operations based on needs of the incident. Notify and then activate the participating network of sites that will dispense/administer medical countermeasures to achieve coverage goals commensurate with the incident.

Task 2: Notify and assemble personnel who will support medical countermeasure dispensing/administration. Alert and assemble personnel who will support medical countermeasure dispensing/administration according to the roles, responsibilities, and resources needed to achieve medical countermeasure coverage goals.

Task 3: Provide medical countermeasures to public health responders and critical workforce. Dispense/administer medical countermeasures to public health responders and critical workforce based on the incident needs and relevant guidance, such as targeting vaccine prioritization to certain population groups.

Task 4: Implement security measures for medical countermeasure dispensing/administration. Implement site-specific security measures to ensure facility safety, personnel safety, product integrity, and crowd management when dispensing or administering medical countermeasures.

Task 5: Provide information to the public. Inform the public about dispensing/administration site locations, operational periods (days and hours open), and populations targeted to receive medical countermeasures.

Preparedness Resource Elements

P1: (Priority) Procedures in place to guide the activation of dispensing/administration sites and the activation of trained personnel, volunteers, and skilled personnel to support those sites, which may include

- Activation procedures for dispensing/administration sites may specify elements, including
  - Site name or identifier
  - Demand estimate (number of people planning to visit the site)
  - Estimated throughput and vaccination capacity
  - Personnel required to operate one shift
  - Number of personnel and shifts required to operate the site throughout the incident
  - Personnel availability
  - Plan to accommodate access and functional needs of at-risk individuals who may be disproportionately impacted by a public health incident or event

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- Mechanisms to address legal and liability barriers may include
  - Clinical standards of care
  - Licensing
  - Civil liability for volunteers
  - Liability for private sector participants
  - Property needed to dispense/administer medical countermeasures

(See Capability 1: Community Preparedness, Capability 6: Information Sharing, and Capability 15: Volunteer Management)

P2: (Priority) Procedures in place to dispense/administer medical countermeasures to public health responders and critical workforce either pre-incident or during the early stages of an incident. Targeting of critical workforce groups would depend on severity of the threat, the risk of severe illness by age group, medical countermeasure supply, and the accompanying disruption to security, society, and the economy. Procedures may include dispensing/administering medical countermeasures to the household members of responders or critical workforce, as indicated in incident-specific targeting guidance.

(See Capability 14: Responder Safety and Health and Capability 15: Volunteer Management)

P3: Security measures, specific to each medical countermeasure dispensing and vaccine administration site, as necessary, to ensure personnel safety, product security, and crowd management during an incident. Security measures may include

- Identifying and activating security personnel
- Safeguarding site property
- Protecting site personnel
- Controlling traffic at and around sites
- Implementing crowd management measures at and around sites
- Collaborating with law enforcement and emergency management
- Formulating evacuation plans
- Developing security breach procedures

(See Capability 14: Responder Safety and Health and Capability 15: Volunteer Management)

P4: List of identified partners and stakeholders for private sector dispensing/administration and procedures to activate private sector partners, as applicable.

P5: Communication messages and procedures in place to develop tailored messages that address various threats and incidents, such as cases of a novel agent. Communication message strategies should be designed to account for individuals with sensory or mobility disabilities and individuals with cognitive, intellectual, developmental, mental, or other disabilities. Communication messages should include

- Tailored messages to meet the specific information needs of the intended audiences, including target populations, at-risk populations, health care providers, and the public
- Guidance from relevant federal or jurisdictional agencies
- Information about site locations, operating hours, and known risks and benefits
- Information that is standardized or harmonized within a jurisdiction or across jurisdictions, such as in cases where media outlets reach audiences across state lines
- Information for populations that are specifically targeted to receive medical countermeasures

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- Information for populations that are not targeted to receive medical countermeasures to ensure that the public understands priorities for allocating limited resources

(See Capability 4: Emergency Public Information and Warning)

Equipment and Technology Resource Elements

E/T1: Equipment for dispensing/administering medical countermeasures may include

- Materiel-handling equipment, such as pallet jacks, handcarts or dollies, and forklifts
- Equipment to ensure proper storage and handling of medical countermeasures, such as refrigerators and temperature tracking for cold chain management
- PPE
- Ancillary medical supplies
- Administrative supplies
- Specialized items, such as scales for weighing children, mixing equipment for pediatric portions, and Broselow tapes

E/T2: Information systems and communication tools to inform the community, target populations, and health care providers about key medical countermeasure information. Systems and tools may include jurisdictional health alert networks, social media, community outreach information network (COIN), or call center systems, such as poison control centers.

(See Capability 4: Emergency Public Information and Warning and Capability 6: Information Sharing)

E/T3: Information systems to support the development and maintenance of staffing models, such as RealOpt©.

E/T4: Equipment and Internet connection, as needed, to access an individual's immunization status as found in an immunization registry, or information about medical conditions as found in an electronic health record.

(See Capability 15: Volunteer Management)

Function 4: Dispense/administer medical countermeasures to targeted population(s)

Function Definition: Provide medical countermeasures to the target population in accordance with public health guidelines and recommendations appropriate to the incident.

Tasks

Task 1: Dispense/administer medical countermeasures to target populations. Identify, screen, and triage target populations to receive medical countermeasures and then to dispense/administer medical countermeasures according to appropriate protocols.

Task 2: Provide essential information to those who receive medical countermeasures. Provide product name, rationale for use and contraindications, point(s) of contact, and other information about the medical countermeasures provided.

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Task 3: Monitor and adjust medical countermeasure dispensing/administration throughput and coverage. Monitor and adjust staffing and supplies to achieve and sustain throughput and coverage goals based on the remaining needs of the population, such as inventory level and remaining regimen use surge or decline.

Task 4: Track medical countermeasures that are dispensed/administered. Maintain inventory management systems to track medical countermeasure inventories and ancillary medical supplies.

Preparedness Resource Elements

P1: (Priority) Procedures in place to dispense/administer medical countermeasures to affected, targeted, and prioritized populations that align with current science, incident characteristics, and public health guidelines. Procedures and guidance may include

- Screening and triaging patients based on patient characteristics, such as age, weight, signs and symptoms, medical history, drug or food allergies, or assessment of exposure
- Ensuring that medical record or log or file of the recipient indicates the following information, as necessary
  - Date the medical countermeasure was provided to the individual
  - Product name, NCD number, lot number, expiration date, and other critical identifying information
  - Health care provider detail, such as name and contact information, prescription number, date of prescription, name of patient (if stated on prescription), directions for use, and cautionary statements
  - Version date of the information statement distributed
- Ensuring medical countermeasure recipients receive the information statement aligned to the medical countermeasure provided
- Ensuring data is recorded to report to state or federal entities, as necessary. Consideration should be given to potential priority status, population demographics, such as sex, age group, and risk factors, and characteristics of the medical countermeasure, such as product name, site, and date
- Ensuring that medical countermeasures are provided according to requirements of applicable state and federal laws or regulations, such as emergency use authorization, investigational new drug protocols, or expanded access to investigational drugs

P2: Drug or vaccine information available to the public and to persons receiving medical countermeasures. Drug and vaccine information may include

- Information for individuals receiving medical countermeasures, such as drug or Vaccine Information Statements (VISs), adapted for targeted populations and languages spoken
- Instructions for return visits, care of injection site, reporting of adverse events, and other key medical information
- Data forms required by federal regulation or other applicable regulations, such as the VISs prescribed by federal law for routine vaccines
- Information needed to ensure medical countermeasures compliance or adherence
- Information about product labeling or expiration, such as relevant consumer-focused information about Shelf Life Extension Program
- Emergency use instructions (fact sheets) developed by CDC about the conditions under which FDA has approved use

(See Capability 10: Medical Surge)

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P3: Procedures in place to request additional personnel and supplies based on incident characteristics. Procedures should describe how the jurisdiction will

- Assess inventory use rates to determine resupply intervals
- Access existing jurisdictional medical caches
- Implement national, regional, and intrastate mutual aid agreements, such as the Emergency Medical Assistance Compact (EMAC)
- Coordinate with relevant agencies, partners and stakeholders including jurisdictional emergency management agencies, HHS RECs, and SNS
- Deploy personnel and supplies to dispensing/administration sites based on public use
- Notify and allocate volunteers

Skills and Training Resource Elements

S/T1: Personnel trained on jurisdictional medical countermeasure tracking systems, such as immunization information systems, electronic health records, or other tracking databases.

Equipment and Technology Resource Elements

E/T1: Information statements, such as drug or vaccine information statements, for persons who receive medical countermeasures. Information statements should be adapted to the needs of target populations, such as accommodating different literacy levels and languages.

E/T2: Information system(s) for dispensing and administering medical countermeasures, such as inventory tracking systems to manage medical countermeasure supplies or state IISs to track vaccinations given to individuals. Backup system(s), such as other inventory management software, electronic spreadsheets, or paper-based systems, must be available in case of emergencies.

Function 5: Report adverse events

Function Definition: Monitor and report or facilitate the reporting of adverse events associated with a medical countermeasure.

Tasks

Task 1: Prepare for adverse event reporting. Assure jurisdictional procedures are in place for adverse event reporting and information dissemination to ensure persons who dispense, administer, or receive medical countermeasures are informed and understand actions to take in the instance of an adverse event.

Task 2: Activate adverse event reporting procedures. Activate adverse event reporting processes to accommodate reporting from any relevant source, including individuals, health care providers, or public health agencies.

Task 3: Promote and facilitate reporting of adverse events. Promote and facilitate reporting of adverse events, disseminate relevant trend data to applicable entities, such as federal agencies, jurisdictional government agencies, and health response partners, and monitor emerging data to inform potential modifications to medical countermeasure strategies.

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Preparedness Resource Elements

P1: (Priority) Procedures in place to guide the reporting of adverse events including receipt of reports and dissemination of adverse event information, to include provisions for adverse event reporting at national and jurisdictional levels. Adverse event reporting procedures should specify

- When and how to use applicable national adverse event reporting systems, such as Vaccine Adverse Events Reporting System (VAERS) or FDA MedWatch Reporting System
- When and how to use adverse event reporting systems that are managed by the jurisdiction
- How to identify and analyze adverse event trends and modify medical countermeasure operations accordingly
- How to communicate emerging trends to health care providers and individuals receiving medical countermeasures
- Data elements to be collected, which may include
  - Name of person who received the vaccine or medication
  - Health care provider
  - Person reporting the adverse event
  - Adverse event being reported
  - Relevant diagnostic tests, laboratory data, and health status
  - Recovery status
  - Vaccine(s) or medications(s) received, date, lot number, dosage
- Written agreements, such as contracts or memoranda of understanding (MOUs), among relevant agencies and clinicians that specify how the jurisdiction will work together to investigate or report adverse events

P2: (Priority) Procedures in place to generate and disseminate pertinent information related to adverse event reporting. Information may include

- Information for persons receiving medical countermeasures regarding potential side effects; for vaccines, these messages are contained in the CDC VISs
- Information for health care providers or individuals to explain how to report adverse events, such as using VAERS or FDA MedWatch system

(See Capability 1: Community Preparedness)

Skills and Training Resource Elements

S/T1: (Priority) Personnel trained on federal and applicable jurisdictional adverse event reporting system procedures, including the designation of a vaccine safety coordinator.

Equipment and Technology Resource Elements

E/T1: Access to national and jurisdictional adverse event reporting systems, such as VAERS, FDA MedWatch, or local reporting systems.

(See Capability 4: Emergency Public Information and Warning and Capability 6: Information Sharing)

Return to Crosswalk

Capability 9: Medical Materiel Management and Distribution

Definition: Medical materiel management and distribution is the ability to acquire, manage, transport, and track medical materiel during a public health incident or event and the ability to recover and account for unused medical materiel, such as pharmaceuticals, vaccines, gloves, masks, ventilators, or medical equipment after an incident.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Direct and activate medical materiel management and distribution
- **Function 2:** Acquire medical materiel from national stockpiles or other supply sources
- **Function 3:** Distribute medical materiel
- **Function 4:** Monitor medical materiel inventories and medical materiel distribution operations
- **Function 5:** Recover medical materiel and demobilize distribution operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Broadens the cold chain management guidance to include all aspects of storage and handling
- Expands recovery activities to incorporate proper handling and disposal of infectious, hazardous, or contaminated materiel and waste
- Accounts for security and inventory management tasks that occur throughout the entire distribution process

For the purposes of Capability 9, partners and stakeholders may include the following:

- emergency management agencies
- emergency medical services (EMS)
- environmental health agencies
- epidemiology programs
- government agencies
- health care coalitions
- health care organizations
- hospitals and health care facilities
- immunization programs
- jurisdictional office(s) of homeland security
- laboratory programs
- law enforcement agencies
- medical professional organizations
- mental/behavioral health services
- pharmacies
- public health agencies
- surveillance programs
- tribes and native-serving organization
- volunteer groups

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Function 1: Direct and activate medical materiel management and distribution

Function Definition: Coordinate with the jurisdictional emergency management agency and health care systems to activate medical materiel distribution operations when an incident exceeds the normal capacity of the jurisdictional supply chain.

Tasks

Task 1: Identify jurisdictional needs for distributing medical materiel. Assess medical materiel response needs based on risk-based scenarios, identify available jurisdictional resources to support medical materiel distribution, and identify potential distribution challenges.

Task 2: Develop procedures to distribute medical materiel. Formulate and update procedures for medical materiel distribution throughout the distribution process, meaning acquisition, management, transport, and tracking during an incident; recovery, disposal, and return or loss after an incident.

Task 3: Establish a network of distribution sites. Identify distribution sites, including receipt, stage, store (RSS), sites regional distribution sites (RDSs), local distribution sites (LDSs), hospitals and health care facilities, or other potential distribution sites, to manage and distribute medical materiel.

Task 4: Develop and establish a transportation strategy. Identify and document transportation assets, based on jurisdictional availability of commercial and governmental transportation resources and establish procedures to mobilize transportation assets based on incident characteristics.

Task 5: Identify and train medical materiel distribution personnel. Identify personnel to manage and distribute medical materiel and ensure identified personnel meet training or certification requirements.

Task 6: Establish an inventory management system. Establish a reliable inventory management system to track medical materiel and exchange inventory-related data with CDC throughout the distribution process.

Task 7: Identify security needs and establish security measures. Identify security needs for personnel, medical materiel, and the network of distribution sites, and establish appropriate security measures based on incident characteristics.

Task 8: Activate medical materiel management and distribution operations. Start procedures to activate identified personnel and the network of distribution sites for medical materiel management and distribution.

Preparedness Resource Elements

P1: (Priority) Assessment of jurisdictional medical materiel needs and distribution response capacity to identify gaps and inform distribution site selection (number of sites and locations), personnel resource requirements, transportation requirements, inventory management strategies, and security measures. The assessment may include

- Inter- and intrajurisdictional roles and responsibilities, such as determining the respective roles of supporting jurisdictional agencies and third party professional warehouse and transportation companies

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- RSS sites, warehousing strategies, and logistical support needs for the jurisdiction's network of distribution sites
- Materiel needs for general and targeted populations, including supplies and resources for populations at risk to be disproportionately impacted by an incident
- Additional resources necessary to execute the jurisdictional medical materiel distribution strategy
- Solutions to address potential transportation challenges, including road closures, inclement weather, power outages, and other challenges
- Anticipated needs of sites, such as hospitals and health care facilities, that would serve as both distribution sites and dispensing/administration sites
- Assessment of distribution needs when medical countermeasures would be delivered through direct ship methods

(See Capability 1: Community Preparedness and Capability 3: Emergency Operations Coordination)

P2: (Priority) Jurisdictional plans that reflect the sequential process of medical materiel distribution, meaning acquisition, management, transport, tracking, recovery, disposal, and return or loss. The planning process may include

- Projecting the types and quantities of medical countermeasures, durable medical equipment (DME), or consumable medical supplies to be provided during an incident
- Building working relationships with professional warehouse companies to formalize resources, roles, and responsibilities
- Coordinating direct ship sites at the dispensing/administration site from a national, centralized distributor
- Building working relationships with commercial or public sector delivery operators to develop and formalize transportation plans
- Establishing staffing estimates for all aspects of medical materiel distribution
- Modeling distribution response times, such as response times for transportation
- Establishing operating procedures and confirming specifications for primary and alternate inventory management systems
- Establishing procedures to resupply distribution sites and dispensing/administration sites

P3: (Priority) Identified lead or jurisdictional authority to initiate medical materiel distribution operations based on incident triggers and incident characteristics.

P4: (Priority) Written agreements, such as contracts or memoranda of understanding (MOUs), with partner and stakeholder organizations to support medical materiel distribution operations.

P5: (Priority) Primary and backup distribution sites capable of receiving, staging, storing, and distributing medical materiel, regardless of the originating supply source, such as the Strategic National Stockpile (SNS), the state immunization program receiving vaccine from Biomedical Advanced Research and Development Authority (BARDA), other vaccine distributors, or commercial sources. Distribution sites should be capable of supplying all dispensing/administration sites in the jurisdiction. Distribution site lists describe characteristics, which may include

- Type of site (commercial vs. government)
- Physical location of site
- 24-hour contact number
- Hours of operation

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- Inventory of materiel-handling equipment on site and list of minimum equipment that need to be procured or delivered at the time of the incident
- Inventory of office equipment on site and a list of minimum equipment or supplies that need to be procured or delivered at the time of the incident
- Inventory of storage equipment, such as refrigerators and freezers on site and a list of minimum storage equipment that needs to be procured or delivered at the time of the incident
- The network of distribution sites may include
- Primary and backup RSS Sites
- RDSs
- LDSs
- Pharmacies or their distribution partner locations
- Hospitals and health care facilities
- Other locations assessed by the jurisdiction as capable distribution sites

P6: A transportation strategy that may include

- List of transportation assets to support distribution of medical materiel to the network of distribution sites
- Routing systems or modeling software used to assist with developing transportation plans
- Primary transport, backup transport, and number of transportation assets
- Vehicle types and load capacities
- Cold chain management and other environmental control management requirements, such as humidity requirements
- Response time(s) to mobilize transportation resources
- Jurisdictional medical materiel suppliers and distributor points of contact to facilitate jurisdictional access to medical materiel
- Delineation of the respective roles of the public health agency, outside vendors, and other partners
- Written agreements, such as contracts or MOUs, with outside transportation vendors. Transportation agreements should specify, at a minimum
  - Type of vendor (commercial vs. government)
  - Number and type of vehicles, including vehicle load capacity and configuration
  - Number and type of drivers, including certification of drivers
  - Number and type of support personnel
  - Response time of vendor(s)
  - Ability of vendor(s) to meet storage and handling requirements, such as cold chain management

P7: Procedures in place to identify and prepare personnel or volunteers to support medical materiel distribution. Procedures may include

- Staffing plans for all categories of distribution sites. Staffing plans may include site leads, alternates, security staff, logistics support staff, and Drug Enforcement Administration (DEA) registrant(s) to sign for controlled medical countermeasures
- Badging and credentialing requirements for personnel at sites
- Training for response personnel and volunteers, including orientation materials, job action sheets, and other training resources or strategies

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- Procedures to request additional personnel from outside the jurisdiction, such as from the National Guard or Medical Reserve Corps (MRC) based on state and local mutual aid agreements in coordination with the jurisdictional emergency management agency
- Procedures for immediate contracting of additional trained distribution support personnel based on state and local emergency procurement practices

(See Capability 3: Emergency Operations Coordination and Capability 15: Volunteer Management)

P8: Procedures in place to ensure security throughout the medical materiel distribution process. Procedures may include

- Designation of security leads and contact information
- Evacuation procedures
- Exterior and interior physical security
- Coordination within and across jurisdictional sovereignty lines for law enforcement and security agencies to secure personnel and facilities
- Physical measures, such as cages, locks, and alarms to secure materiel within the distribution site
- Security measures for transporting materiel, such as escorts and securing of designated roadways
- Security measures at alternate distribution sites
- Traffic control staffing
- Worker safety
- Cybersecurity measures, such as protection of personally identifiable information and prevention of unauthorized use of social media

(See Capability 3: Emergency Operations Coordination, Capability 6: Information Sharing, Capability 8: Medical Countermeasure Dispensing and Administration, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

Skills and Training Resource Elements

S/T1: Personnel trained to manage and distribute medical materiel in alignment with jurisdictional procedures. Job action sheets for key distribution positions may include

- Distribution lead
- Logistics lead
- Receiving site lead(s)
- Security lead
- Inventory management
- DEA registrant

S/T2: Personnel trained to use and manage inventory management systems that track medical materiel throughout the distribution process.

S/T3: Personnel trained to conduct tabletop, functional, and full-scale exercises in accordance with the Homeland Security Exercise and Evaluation Program (HSEEP) guidance to test and evaluate jurisdictional medical materiel management and distribution strategies.

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Equipment and Technology Resource Elements

E/T1: Transportation assets scalable for distributing medical materiel to distribution sites based on incident characteristics and logistical conditions. Incident characteristics and logistical conditions may include

- Vehicle types and load capacity
- Response time(s) for mobilizing initial transportation resources
- Warehouse characteristics, including loading dock type and quantity, staging and storage footprint, and cold chain resources
- Delivery vehicle characteristics, including compatibility of the vehicle(s) with loading dock, presence of lift gate, and capacity for full pallet
- Receiving site characteristics, including compatibility to receive a full pallet, loading dock type, and on-site equipment
- Medical countermeasure characteristics, including the total quantity, weight, and size of the shipments, storage and handling requirements, and packaging
- Distribution plan characteristics, including the number of delivery vehicles that can be allocated simultaneously, routes, and security escorts

E/T2: Inventory management system(s) to coordinate and account for medical materiel receipt and distribution, such as CDC's Inventory Management and Tracking System (IMATS). Interoperable information systems to exchange and store inventory-related data. Inventory management system requirements may include

- Compliance with Inventory Data Exchange (IDE) standards or interoperability with CDC information systems
- Ability to track the name of drug, quantity, National Drug Code number, lot number, dispensing/administration site, expiration date, and unit configuration of issue, such as case, box, or bottles
- Backup systems for redundancy, such as alternate inventory management software, electronic spreadsheets, or paper-based systems

(See Capability 6, Information Sharing)

E/T3: Equipment needed to maintain security for personnel and facilities, which may include

- Physical security measures, such as cages, locks, and alarms
- Personal protective equipment (PPE)

(See Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

Function 2: Acquire medical materiel from national stockpiles or other supply sources

Function Definition: Acquire, receive, stage, and store medical materiel from jurisdictional caches or from private, regional, or federal partners.

Tasks

Task 1: Acquire medical materiel. Request or obtain medical materiel to meet the needs of the jurisdiction based on incident characteristics.

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Task 2: Manage medical materiel. Receive, stage, and store medical materiel in accordance with manufacturer specifications.

Preparedness Resource Elements

P1: (Priority) Procedures in place to request medical materiel for both initial requests and resupply requests whether sourced from SNS, the state immunization program, or other source. Procedures may include

- Defined request triggers, indicators, thresholds, and validation strategies to guide decision-making
- Identification of individuals within the jurisdiction empowered with the authority to request federal, state, local, tribal, and territorial assets, such as emergency management representatives, senior health officials, and elected representatives with statutory authority to request mutual aid
- Strategies to use local circulating inventories and existing jurisdictional medical countermeasure caches
- Strategies to use existing infrastructure, such as state immunization programs with experience in vaccine ordering and distribution through the Vaccines for Children Program
- Special provisions that may affect medical materiel request procedures
  - Stafford Act vs. non-Stafford Act declarations
  - Declarations of a public health emergency
  - Procedures to coordinate with U.S. Department of Health and Human Services (HHS), as required
- Procedures to request medical materiel through the Emergency Medical Assistance Compact (EMAC)
- Protocols to ensure compliance with regulatory standards, including
  - U.S. Food and Drug Administration (FDA) standards
  - Current Good Manufacturing Practices (cGMP)
  - Appropriate DEA registrations
- Procedures to obtain medical materiel outside of the SNS, such as pandemic influenza vaccine anticipated to be supplied in coordination with the jurisdiction's immunization program and CDC's centralized distributor for publicly funded vaccines
- Identification of local pharmaceutical and medical supply wholesalers
- Processes to justify requests for medical countermeasures and other medical materiel

(See Capability 3: Emergency Operations Coordination and Capability 8: Medical Countermeasure Dispensing and Administration)

P2: (Priority) Procedures in place to receive, stage, and store medical materiel. Procedures may include

- Facility characteristics, such as docks, open floor space, and climate
- Maintenance of cold chain integrity according to storage and handling guidelines
- Storage and access of controlled substances
- Access for authorized persons
- Security measures, including personnel, physical security, and other security measures

Skills and Training Resource Elements

S/T1: Personnel trained on procedures to request and manage medical materiel in accordance with manufacturer specifications and jurisdictional procedures.

Return to Crosswalk

Equipment and Technology Resource Elements

E/T1: Materiel-handling equipment at receiving sites (provision of equipment may be included in contracts or memoranda of understanding with receiving sites). Equipment may include

- Pallets and pallet jacks
- Handcarts or dollies
- Forklifts
- Cold chain storage equipment

Function 3: Distribute medical materiel

Function Definition: Transport medical materiel to receiving sites based on incident needs.

Tasks

Task 1: Transport medical materiel to receiving sites. Activate strategies for apportioning and transporting medical materiel to distribution sites and dispensing/administration sites.

Task 2: Ensure product integrity of medical materiel. Maintain medical materiel integrity in accordance with established safety and manufacturer specifications during transport and distribution.

Preparedness Resource Elements

P1: **(Priority)** Procedures in place to apportion and transport medical materiel, which may include

- Delivery locations and routes
- Delivery schedule/frequency
- Respective roles and responsibilities of public health agencies, transportation partners, and other relevant entities

P2: Written agreements with receiving sites and transportation partners to ensure distribution of medical materiel.

(See Capability 8: Medical Countermeasure Dispensing and Administration)

Skills and Training Resource Elements

S/T1: Personnel trained to apportion and transport medical materiel.

Equipment and Technology Resource Elements

E/T1: Equipment and supplies for the distribution of medical materiel at receiving site(s) that are scalable to receiving site operations, incident characteristics, and logistical conditions.

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Function 4: Monitor medical materiel inventories and medical materiel distribution operations

Function Definition: Maintain real-time situational awareness of medical materiel management and distribution in order to address emerging needs for resupply, security, transportation, and use of receiving sites.

Tasks

Task 1: Identify and respond to medical materiel resupply needs. Monitor inventory status reports and request resupply based on demand and incident needs.

Task 2: Monitor security of medical materiel operations. Maintain situational awareness of security needs throughout the duration of the incident and adjust security measures, as necessary.

Task 3: Monitor transportation operations. Maintain situational awareness of transportation assets and adjust transportation plans, as necessary.

Task 4: Monitor receiving sites and associated personnel. Assess the effectiveness and efficiency of receiving sites and adjust operations, as applicable.

Preparedness Resource Elements

P1: (Priority) Procedures in place to report inventory status to federal, regional, state, local, tribal, and territorial authorities. Inventory status reports should include

- Amount of medical materiel received
- Additional information about medical materiel received, including receipt date, time, and name of individual who accepted custody of materiel
- Amount of medical materiel distributed
- Current available quantity of medical materiel

(See Capability 6: Information Sharing)

P2: (Priority) Procedures in place to request resupply for distribution sites that specify information, which may include

- Date of request
- Date of medical materiel receipt
- Urgency of medical materiel needs
- Receiving site addresses
- Distribution strategy, such as distribution through established channels or direct-ship from vendor
- Specifics of the requested medical materiel, including item type, size, quantity, intended use, and other relevant information to aid fulfillment choices
- Requestor (or other point of contact) information
- Justifications for resupply

(See Capability 3: Emergency Operations Coordination and Capability 8: Medical Countermeasure Dispensing and Administration)

Return to Crosswalk

P3: (Priority) Procedures in place to assess ongoing security measures throughout the distribution process and make adjustments, as necessary. Security measures may be assessed with information from sources, which may include

- Security coordinator
- Law enforcement and security agencies that secure personnel, transportation, and facilities
- Incident management personnel, such as command staff or general staff
- Transportation or warehouse personnel

P4: Procedures in place to resupply, replace, or adapt transportation assets based on incident characteristics and emerging needs.

Skills and Training Resource Elements

S/T1: Supplemental inventory management personnel trained and ready to sustain medical materiel distribution throughout the response.

Equipment and Technology Resource Elements

E/T1: Ongoing access to physical security measures, such as cages, locks, and alarms, for maintaining security of materiel throughout the distribution process.

E/T2: Ongoing access to primary or backup system(s) to manage inventory.

Function 5: Recover medical materiel and demobilize distribution operations

Function Definition: Recover remaining medical materiel and demobilize distribution operations in accordance with jurisdictional policies, federal regulations, and incident characteristics.

Tasks

Task 1: Identify recovery and demobilization needs. Determine the needs of the jurisdiction to recover medical materiel and scale down medical materiel management operations.

Task 2: Recover medical materiel. Recover remaining medical materiel when demobilizing jurisdictional distribution operations.

Task 3: Return or dispose of unused medical materiel. Account for, return, or dispose of unused and unopened medical materiel.

Task 4: Demobilize distribution operations. Deactivate transportation assets, receiving sites, and personnel.

Task 5: Dispose of biomedical waste or other hazardous material. Dispose of biomedical and other potentially infectious, hazardous, or contaminated materials and waste.

Task 6: Prepare after-action reports and improvement plans. Document within an after-action report (AAR) the strengths and challenges encountered during the medical materiel distribution process and develop a corresponding improvement plan (IP).

Task 7: Implement IPs. Implement an IP based on the identified opportunities for improvement.

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Preparedness Resource Elements

P1: (Priority) Procedures in place to demobilize operations, including the release of personnel, closure of distribution sites, recovery of unused medical materiel, and disposal of biomedical waste, according to laws and regulations and in coordination with the health care system and the jurisdictional emergency management agency, as required.

(See Capability 3: Emergency Operations Coordination, Capability 10: Medical Surge, and Capability 15: Volunteer Management)

P2: Procedures in place to store, distribute, dispose of, or return unused or unopened materiel, including pharmaceuticals and durable items, in compliance with federal or jurisdiction-specific regulations and product-specific guidance from the manufacturer.

P3: Procedures in place to dispose of biomedical waste or other hazardous materials with appropriate waste management procedures that comply with applicable laws and regulations, such as disposal of chemical or radiological material.

(See Capability 14: Responder Safety and Health)

P4: Procedures in place to complete an AAR and IP consistent with HSEEP guidance, which may include

- Critical information required to determine the areas of strength and areas for improvement following an incident
- A timeline to ensure completion of after-action reporting and development of corrective action or IPs

(See Capability 3: Emergency Operations Coordination)

Skills and Training Resource Elements

S/T1: Personnel trained on medical materiel and equipment recovery according to manufacturer and jurisdictional guidelines.

S/T2: Personnel trained on established procedures for disposal of unused or unopened medical materiel, pharmaceuticals, durable items, and hazardous materials and medical waste.

S/T3: Personnel trained on established procedures for after-action reporting, including the National Incident Management System (NIMS) and HSEEP trainings.

(See Capability 3: Emergency Operations Coordination)

Return to Crosswalk

Capability 10: Medical Surge

Definition: Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services, including disease surveillance, epidemiological inquiry, laboratory diagnostic services, and environmental health assessments.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Assess the nature and scope of the incident
- **Function 2:** Support activation of medical surge
- **Function 3:** Support jurisdictional medical surge operations
- **Function 4:** Support demobilization of medical surge operations

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Emphasizes the need to define public health agency lead and support roles within medical surge operations
- Eliminates use of the term "HAvBED" because the term is no longer promoted by the Hospital Preparedness Program (HPP),[8] and focuses instead on "situational awareness" and "health care systems tracking" as an overarching theme
- Emphasizes the need to identify and clarify the jurisdictional Emergency Support Function (ESF) #8 response role in medical surge operations based on jurisdictional role and incident characteristics

For the purposes of Capability 10, partners and stakeholders may include the following:

- ambulatory care providers
- clinics
- emergency management agencies
- emergency medical services (EMS)
- environmental health
- fire departments
- health care coalitions
- health care organizations
- health professional volunteer entities[9]
- law enforcement agencies
- long-term care agencies
- mental/behavioral health pharmacies
- poison control centers
- public health agencies
- public works
- social services
- stand-alone emergency rooms
- state hospital associations
- tribes and native-serving organizations
- urgent care
- volunteer organizations[10]

[8] Subject matter experts from the HHS Office of the Assistant Secretary for Preparedness and Response Hospital Preparedness Program made significant contributions to the updates for Capability 10: Medical Surge

[9] For example, the National Voluntary Organizations Active In Disaster (NVOAD), and the National Disaster Medical System (NDMS)

[10] For example, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), and the Medical Reserve Corps (MRC)

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Function 1: Assess the nature and scope of the incident

Function Definition: Coordinate with Emergency Support Function (ESF) #8 partners, the jurisdiction's health care response, and other partners and stakeholders to define incident needs and available health care personnel and resources through the collection and analysis of data, including resource tracking data, data resulting from mutual aid agreements, such as the Emergency Management Assistance Compact (EMAC), disease surveillance data, and other applicable health data.

Tasks

Task 1: Define the role of the public health agency in medical surge. Identify jurisdictional public health medical surge lead or support roles and responsibilities in coordination with other jurisdictional authorities and partners.

Task 2: Evaluate the structural needs of the jurisdictional incident management system. Support the jurisdictional incident management system to determine the public health medical surge role within the Incident Command System (ICS).

Task 3: Complete incident assessments. Assess and document initial needs and availability of resources, including personnel, facilities, logistics, and other health care resources.

Task 4: Exchange data with jurisdictional health care organizations or health care coalitions. Provide public health data to jurisdictional health care organizations or health care coalitions to support activation of plans, if required, to maximize scarce resources and prepare for shifts into and out of conventional, contingency, and crisis standards of care.

Preparedness Resource Elements

P1: (Priority) Personnel trained and assigned to fill public health incident management roles, as applicable, to a medical surge response to include emergency operations center (EOC) staffing at agency, local, and state levels as necessary.

(See Capability 3: Emergency Operations Coordination)

P2: (Priority) Procedures in place to ensure coordination with jurisdictional partners and stakeholders for emergency incidents, exercises, and pre-planned (recurring or special) events in accordance with ICS organizational structures, doctrine, and procedures, as defined by the National Incident Management System (NIMS).

P3: Bidirectional situational awareness system between public health and health care organizations to assess and maintain visibility of emergency surge resources. Situational awareness system activities may include

- Regularly assessing staffing surge across facilities and locations
- Routinely tracking bed availability including specialty beds across facilities, as necessary
- Continually tracking, allocating, and comprehensively managing medical materiel
- Sharing ongoing epidemiological and surveillance data that may impact resource use
- Sharing ongoing findings from community and environmental assessments

(See Capability 6: Information Sharing and Capability 9: Medical Materiel Management and Distribution)

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P4: (Priority) Procedures in place for public health to engage the health care system and health care coalitions to collect, provide, and receive situational awareness in alignment with health care system institutional and jurisdictional expectations. Jurisdictional health care system or coalition responsibilities may include

- Including health care system emergency response planning into jurisdictional and state response plans
- Preparing to address the needs of communities and at-risk individuals who may be disproportionately impacted by a public health incident or event, including children, pregnant women, older adults, and others with access and functional needs, as defined by the Communication; Maintaining Health; Independence; Support, Safety and Self-determination; Transportation (CMIST) framework.
- Minimizing duplication of effort by supporting coordination among federal, state, local, tribal, and territorial planning, preparedness, response, and demobilization activities
- Coordinating with jurisdictional emergency management organizations and assisting the health care system at the level necessary to maintain continuity of operations if standard operations are overwhelmed and disaster operations become necessary
- Supporting jurisdiction-wide situational awareness to ensure the maximum number of people requiring care receive safe and appropriate care, including facilitating triage and directing people to appropriate facilities and providing facility support

P5: Procedures in place to define when the jurisdiction's health care system and health care coalitions transition into and out of conventional, contingency, and crisis standards of care during an incident based on the level of stress on the health care system. This may include assessing risks to formalize strategies that define transition processes and indicators in coordination partners and stakeholders.

(See Capability 1: Community Preparedness)

P6: Procedures in place for the inclusion of partners to assist in the effective management of medical surge needs, such as balanced use of population-based interventions.

P7: Ongoing communications, community messaging, and data sharing with the health care system, health care coalitions, public safety answering points, such as 911 emergency medical dispatch systems, poison control centers, and EMS organizations. This may include requesting and using National Emergency Medical Services Information System (NEMSIS) data elements.

(See Capability 1: Community Preparedness, Capability 3: Emergency Operations Coordination, Capability 4: Emergency Public Information and Warning, Capability 6: Information Sharing, Capability 7: Mass Care, Capability 9: Medical Materiel Management and Distribution, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 15: Volunteer Management)

Skills and Training Resource Elements

S/T1: Personnel trained to use NEMSIS and 911 data.

S/T2: Personnel trained to use the jurisdictional bed-tracking system to obtain data for jurisdictional situational awareness activities.

S/T3: Personnel trained for the role of the public health agency programs in incident response requiring medical surge. Training materials may include

- ESF #8—Public Health and Medical Services (IS-808)
- Introduction to Incident Command System (IS-100.b)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)

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- National Incident Management System, An Introduction (IS-700.a)
- National Response Framework, An Introduction (IS-800.b)

Equipment and Technology Resource Elements

E/T1: Primary and backup Internet connection to access local and state NEMSIS, 911 data, or access bed-tracking data.

E/T2: Jurisdictional situational awareness system coordinated with the health care system and health care coalitions as necessary.

Function 2: Support activation of medical surge

Function Definition: Convene subject matter experts to discuss incident-specific changes to clinical care in protracted incidents, such as pandemic influenza, and expand access to health care services, such as call centers, alternate care systems, EMS, inpatient services, pharmacies, and occupational health clinics, during a surge on the jurisdiction's health care system from an incident or event. Support the health care system, health care coalitions, and response partners based on identified public health response role(s), including providing recommendations for allocation of scarce resources.

Tasks

Task 1: Mobilize medical surge personnel. Support mobilization of incident-specific medical and mental/behavioral treatment personnel, public health personnel, and support personnel.

Task 2: Activate alternate care facilities. Assist health care organizations and health care coalitions with monitoring and activating alternate care facilities, as requested.

Task 3: Support additional health care services. Assist with the surge of the health care system through coordination with health care coalitions, including hospitals and non-hospital entities.

Task 4: Ensure situational awareness. Support situational awareness by using real-time information exchange among response partners, the health care system, and health care coalitions.

Task 5: Coordinate public education opportunities. Provide information to educate the public regarding available health care services, and adapt messaging for populations that may be disproportionately impacted by the incident, including individuals with access and functional needs.

Preparedness Resource Elements

P1: (Priority) Procedures in place that indicate how the jurisdictional public health agency will access volunteer resources through ESAR-VHP, the MRC health professional volunteer entities, such as NVOAD, and other personnel resources.

(See Capability 15: Volunteer Management)

P2: (Priority) Procedures in place that indicate how the public health agency will engage with health care coalitions and other response partners in the development and execution of health and medical response plans, integrating the access and functional needs of at-risk individuals who may be disproportionately impacted by a public health incident or event to meet incident and medical surge needs. Procedures may include

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- Written list of health care organizations, coalitions, and human services providers that can support the access and functional needs of at-risk individuals
- Communication strategies for coalitions, including health care organizations and human services providers, in advance of an event
- Current (up-to-date) list of available human services organizations that provide support and services to address the access and functional needs of at-risk individuals
- Pre-identified site(s) that have undergone an initial assessment to determine their adequacy to serve as an alternate care facility

P3: (Priority) Jurisdictional procedures in place to identify critical information sharing requirements (situational awareness information) for partners and stakeholders. Procedures for characterizing critical information requirements may include

- Identifying, defining, and establishing essential information and requirements
- Determining elements of information needed to establish a common operating picture
- Identifying data owners
- Validating data with stakeholders

(See Capability 6: Information Sharing)

P4: (Priority) Procedures in place to document participation from jurisdictional and regional pediatric and geriatric providers, trauma centers, and burn centers in a variety of settings, such as maternal and child health programs, clinic-based, hospital-based, long-term care, and rehabilitation within jurisdictional response planning. Recommended procedures may include

- Identification of gaps in the provision of pediatric and geriatric care
- Coordination of pediatric and geriatric care within the jurisdiction
- Coordination with jurisdictional trauma and burn centers

(See Capability 1: Community Preparedness, Capability 2: Community Recovery, and Capability 4: Emergency Public Information and Warning)

P5: Procedures in place to connect health care organizations and providers with additional volunteers or other personnel through volunteer or staffing programs, such as ESAR-VHP, MRC, and the National Disaster Medical System (NDMS), if necessary.

(See Capability 15: Volunteer Management)

P6: Procedures in place to provide support for the integration of MRC units with local, regional, and statewide infrastructure. Recommended procedures may include

- Supporting MRC personnel or coordinators for the primary purpose of integrating the MRC structure with the state ESAR-VHP program or other volunteer management process
- Including MRC volunteers in trainings and exercises that are integrated with other regional, state, local, tribal, territorial assets, health care systems, or volunteers through the ESAR-VHP program

(See Capability 15: Volunteer Management)

P7: Written agreements, such as contracts or memoranda of understanding MOUs, with partner agencies, if needed, to create formal and informal partnerships with jurisdictional volunteer sources.

(See Capability 15: Volunteer Management)

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P8: Pre-identified potential locations for Federal Medical Stations (FMSs) and potential alternate care sites that have been assessed for environmental suitability in partnership with the applicable U.S. Department of Health and Human Services (HHS) Regional Emergency Coordinator(s) (RECs).

P9: Partnership with the applicable HHS RECs to address the need for wrap-around services, such as facility security, biomedical, and medical waste disposal, or provide information regarding accessing other services, such as food service at projected FMS locations.

P10: Procedures in place to staff call centers with volunteer resources to manage increased call volumes at health care organizations and health care coalitions.

(See Capability 15: Volunteer Management)

P11: Procedures in place to create, clear or approve, and disseminate medical surge guidance to inform the population of where and when to seek care as well as the appropriate use of 911 and acute care health systems during an incident or event. Considerations for making messages accessible for individuals with access and functional needs may include

- Developing translated materials or resources that are accessible for people with limited English proficiency and that are linguistically appropriate, culturally sensitive, and account for varied literacy levels
- Developing materials or resources that are accessible for people who are blind, have low vision, are deafblind, or have other visual disabilities
- Developing materials or resources that are accessible for people who are deaf, hard of hearing, deafblind, or have other hearing disabilities

(See Capability 1: Community Preparedness and Capability 4: Emergency Public Information and Warning)

P12: Procedures in place for the local EMS system to request additional resources, such as specialty equipment and personnel, for the needs of pediatric cases as part of the jurisdictional ESF #8 annex or other documentation.

P13: Legal and regulatory mechanisms to support surge activities at the jurisdictional level and identification and engagement of the health care workforce to execute the mechanisms. Recommended considerations may include

- Liability protections for providers or facilities
- Allowances and limitations for Health Insurance Portability and Accountability Act (HIPAA) compliance
- Ability to commandeer resources
- Ability to change regulations to support emergency and alternate systems of care

Skills and Training Resource Elements

S/T1: Personnel trained and knowledgeable on the Strategic National Stockpile (SNS) formulary and trained on FMS implementation.

S/T2: Personnel trained on providing care to pediatric patients and using pediatric equipment.

Equipment and Technology Resource Elements

E/T1: **(Priority)** Incorporation of equipment, communication, and data interoperability into the health care organizations' acquisition programs.

(See Capability 6: Information Sharing)

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Function 3: Support jurisdictional medical surge operations

Function Definition: Coordinate health care resources in conjunction with response partners, including the tracking of patients, medical personnel, equipment, and supplies from intra- or inter-state and federal partners, if necessary, in quantities needed to support medical response operations.

Tasks

Task 1: Maintain communications and continuity of services. Coordinate and maintain communications per jurisdictional authority or jurisdictional incident management structure with partners and stakeholders to maintain situational awareness, account for jurisdictional needs, and maintain continuity of medical response operations.

Task 2: Coordinate with partners to provide required resources. Assess resource requirements during each operational period and coordinate with partners, including those able to provide mental/behavioral health services for the community, to obtain necessary resources and to support medical surge.

Task 3: Track patients impacted by the incident. Coordinate with jurisdictional partners and stakeholders to facilitate patient tracking during the incident response and recovery.

Preparedness Resource Elements

P1: (Priority) Procedures in place to collect, communicate, and share situational awareness information, including number and types of patients seen by location, to partners and stakeholders through jurisdictional emergency management procedures.

(See Capability 6: Information Sharing and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P2: (Priority) Procedures in place that detail jurisdictional public health agency participation in the development and execution of health and medical response and recovery plans that integrate the access and functional needs of populations at risk of being disproportionately impacted by the incident or event.

(See Capability 1: Community Preparedness and Capability 2: Community Recovery)

P3: (Priority) Procedures in place to support or implement family reunification.

P4: (Priority) Public health and health care system coordination procedures that account for public health and medical materiel management, inventory assessments, and personnel and equipment resource requests from jurisdictional and other ESF #8 partners as the incident evolves. Recommended considerations may include

- Management of available medical supplies, medications, and vaccines
- Use of jurisdictional medical caches
- Processes for requesting additional supplies
- Availability of ventilators (portable or otherwise) within the jurisdiction
- Management of laboratory diagnostic services, for example equipment and supplies
- Field- and facility-based epidemiological tracking

(See Capability 8: Medical Countermeasure Dispensing and Administration, Capability 9: Medical Materiel Management and Distribution, Capability 12: Public Health Laboratory Testing, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 15: Volunteer Management)

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P5: Jurisdictional patient-tracking and disease surveillance systems operated in conjunction with state and local emergency management, EMS, health care organizations, and other jurisdictional partners. Recommended considerations for patient-tracking systems may include

- Close coordination with state government systems
- Interoperability with relevant state and national patient-tracking systems and registries
- Consistency with federal and state-approved privacy protection, regulations, and standards for patient-tracking systems and registries

(See Capability 6: Information Sharing and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P6: Procedures in place to coordinate with the jurisdiction's patient-tracking system, including immunization information systems (IISs), local and state EMS, and 911 authorities, as applicable.

(See Capability 6: Information Sharing)

Equipment and Technology Resource Elements

E/T1: Electronic or other data storage systems to inform situational awareness, such as the jurisdiction's IIS and Joint Patient Assessment and Tracking System (JPATS), in accordance with national standards.

(See Capability 6: Information Sharing)

Function 4: Support demobilization of medical surge operations

Function Definition: In conjunction with jurisdictional partners, return the health care system to pre-incident operations by incrementally decreasing surge staffing, equipment needs, alternate care facilities, and other systems and transitioning patients from acute care services into their pre-incident medical environments or other applicable medical settings.

Tasks

Task 1: Assist in the return movement of patients. Assist or coordinate with partners to return patients to their pre-incident medical environments, such as prior medical care provider, skilled nursing facility, or place of residence, or other applicable medical settings.

Task 2: Assist the health care system in the demobilization of resources. Coordinate with partners to demobilize health care resources including facilities, personnel, and equipment according to incident needs. Ensure effective discharge planning for people with disabilities and other access and functional needs to avoid inappropriate placement, and maintain independent living in the least restrictive environment.

Task 3: Demobilize alternate care facilities and mutual aid resources. Coordinate with partners to demobilize alternate care facilities and resources obtained through mutual aid, EMAC, and other means of assistance, as appropriate for the incident.

Preparedness Resource Elements

P1: (Priority) Procedures in place to coordinate with state EMS to demobilize transportation assets used in the incident.

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P2: (Priority) Procedures in place to demobilize surge personnel, including state medical personnel, such as MRC, and federal medical personnel, such as NDMS, and to use thresholds and indicators to detect the need for further demobilization of personnel and other medical surge resources.

(See Capability 15: Volunteer Management)

P3: Communication between public health and the health care system, health care coalitions, and community partners to maintain situational awareness of health care system impacts that may inform demobilization priorities.

P4: Procedures in place to coordinate case management or other support to assist in the transition to pre-incident medical environments or other applicable medical settings, as requested by health care organizations based on the public health lead or support role.

(See Capability 2: Community Recovery)

P5: Coordinated procedures to communicate with HHS Regional Health Administrators (RHAs); regional directors; state, local, tribal, territorial, or county agencies; and HHS RECs to address the access and functional needs of patients during the demobilization of medical surge efforts.

P6: Coordination of jurisdictional authorities and partner groups to support volunteer and other personnel post-deployment medical screening, stress and well-being assessment, and, when requested or indicated, referral to medical and mental/behavioral health services.

(See Capability 2: Community Recovery, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

P7: Procedures in place to release volunteers and other personnel when the public health agency has the lead role or supporting role in the coordination of volunteers or other personnel. Recommended procedures may include

- Demobilizing volunteers and other personnel in accordance with the incident action plan
- Completing all assigned activities or informing replacement volunteers of the activities' status
- Determining additional assistance needed from volunteers or other personnel
- Returning equipment used by volunteers or other personnel
- Recording follow-up contact information for volunteers and other personnel

(See Capability 3: Emergency Operations Coordination and Capability 15: Volunteer Management)

P8: Exit screening procedures for out-processing activities. Screening elements may include

- Injuries and illnesses acquired during the response
- Mental/behavioral health needs resulting from the response
- Referral of volunteers to medical and mental/behavioral health services, as requested or indicated

(See Capability 3: Emergency Operations Coordination, Capability 7: Mass Care, Capability 9: Medical Materiel Management and Distribution, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

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Capability 11: Nonpharmaceutical Interventions

Definition: Nonpharmaceutical interventions are actions that people and communities can take to help slow the spread of illness or reduce the adverse impact of public health emergencies. This capability focuses on communities, community partners, and stakeholders recommending and implementing nonpharmaceutical interventions in response to the needs of an incident, event, or threat. Nonpharmaceutical interventions may include

- Isolation
- Quarantine
- Restrictions on movement and travel advisories or warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Engage partners and identify factors that impact nonpharmaceutical interventions
- **Function 2:** Determine nonpharmaceutical interventions
- **Function 3:** Implement nonpharmaceutical interventions
- **Function 4:** Monitor nonpharmaceutical interventions

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Focuses on collaboration by expanding suggested partners for implementing nonpharmaceutical interventions (NPIs)
- Supports establishment of community reception center processes to enhance ability to respond to radiological and nuclear threats
- Highlights management of mass gatherings (delay and cancel) based on all-hazards scenarios

For the purposes of Capability 11, partners and stakeholders may include the following:

- agriculture departments
- businesses
- community and faith-based organizations
- environmental health agency
- government agencies
- groups representing and serving populations with access and functional needs
- health care organizations
- jurisdictional emergency management agency
- law enforcement
- legal authorities
- mental/behavioral health agencies
- public health agencies
- school districts
- social services
- state radiation control programs
- travel and transportation agencies
- tribes and native-serving organizations

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Function 1: Engage partners and identify factors that impact nonpharmaceutical interventions

Function Definition: Engage with partners and stakeholders to identify authorities, policies, and community factors that guide decision-making about NPIs and to determine jurisdictional roles and responsibilities for NPIs.

Tasks

Task 1: Identify authorities, policies, and other factors that impact NPIs. Identify jurisdictional, legal, and regulatory authorities and policies as well as other community factors that enable or limit the ability to recommend and implement NPIs.

Task 2: Determine jurisdictional roles and responsibilities related to NPIs. Determine jurisdictional lead and support roles for implementing NPIs, and confirm roles and responsibilities among partners and stakeholders.

Preparedness Resource Elements

P1: (Priority) Documentation of applicable jurisdictional, legal, and regulatory authorities and policies for recommending and implementing NPIs in incident-specific situations. Develop and incorporate guidance to address existing legal and policy gaps with assistance from legal counsel or academic partners as necessary. Policies and guidance may include

- Written agreements, such as contracts or memoranda of understanding (MOUs), with law enforcement that describe how NPIs would be implemented
- Procedures for how decision-making processes are used to identify the most effective NPIs while imposing the least amount of restrictions on individual rights
- Criteria for initiating and ceasing use of NPIs
- Written agreements with community partners outlining roles, responsibilities, and access to necessary resources to implement NPIs
- Contact information for representatives from partner agencies and organizations
- Written agreements with health care providers to establish a common operating picture, including
  - Procedures to communicate case definitions to health care providers, as determined from epidemiological surveillance
  - Procedures for health care providers to rapidly report suspected and confirmed cases to the public health agency
- Assessment of the access and functional needs of at-risk individuals who may be disproportionately impacted by the incident and plans to address identified access and functional needs

(See Capability 1: Community Preparedness, Capability 6: Information Sharing, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P2: (Priority) Identification and documentation of local conditions or incident characteristics that are relevant to the NPI decision-making process. These factors may include

- Individuals and groups, such as active monitoring and restriction of movement
- Facilities, such as health care facilities, safe housing, and shelters
- Animals, such as service animals, ill animals, animals exposed to infectious diseases, and animals exposed to environmental, chemical, and radiological hazards

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- Food safety, such as contaminated consumer food products
- Imported items that fall under federal regulations, such as human remains, human tissues or products, animal meat, trophy shipments, and non-human primate shipments
- Public works and utilities, such as water supply
- Travel through ports of entry

Function 2: Determine nonpharmaceutical interventions

Function Definition: Collaborate with subject matter experts and community representatives to make recommendations for NPIs based on incident characteristics and subject matter expertise in applicable specialties, such as epidemiology, laboratory, surveillance, health care, chemistry, biology, radiology, social service, emergency management, and law enforcement.

Tasks

Task 1: Engage subject matter experts to assess exposure or transmission. Assemble subject matter experts to assess the severity of exposure or transmission at the jurisdictional level and the need for NPIs.

Task 2: Develop recommendations for NPIs. Identify NPI recommendations based on science, risks, resource availability, and legal authorities.

Preparedness Resource Elements

P1: Decision matrix indicating questions for public health leadership and recommendation options based on existing community risk assessments and incident severity.

P2: (Priority) Procedures in place to develop NPI recommendations specific to the incident and based on science, risks, resource availability, and legal authorities. Categories of NPIs may include

- Separation of individuals with a contagious disease from individuals who are not sick (isolation)
- Separation or restricted movement of healthy, but exposed individuals to determine if they are ill (quarantine)
- Restrictions on movement and travel advisories and warnings, such as screening at port of entry, limiting public transportation, and issuing travel precautions
- Social distancing
  - School and childcare closures
  - Postponement or cancellation of mass gatherings
  - Closures and modifications of workplace or community events
- External decontamination
- Hygiene and sanitation
- Precautionary protective behaviors, such as personal decontamination, shelter in place, and face mask in special situations during severe pandemics

NPI recommendations may include

- Personnel and subject matter expert roles and responsibilities
- Intervention actions and their associated legal and public health authorities
- Pre-identified locations with specific equipment or easily adaptable locations

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- Contact information and notification plans for community partners involved in intervention, meaning those providing services or equipment
- Impact of any secondary effects of implementing measures, such as needs for additional security or provision of essential goods and services to isolated or quarantined persons
- Intervention-specific methods for disseminating information to the public, such as methods to distribute information at ports of entry during public health events
- Processes for the phasedown of interventions when they are no longer needed
- Processes to supplement existing resources for surge capacity
- Guidance for health educators about NPIs
- Guidance for individuals about NPIs
- Identification of considerations that can inform decision making about starting or stopping use of NPIs

(See Capability 1: Community Preparedness, Capability 4: Emergency Public Information and Warning, Capability 13: Public Health Surveillance and Epidemiological Investigation, and Capability 14: Responder Safety and Health)

Skills and Training Resource Elements

S/T1: Personnel trained to understand jurisdictional risks, legal authorities, and options for implementing NPIs based on the best available science.

S/T2: Personnel trained to understand and implement their respective agency role(s) and responsibilities as they relate to NPIs.

Function 3: Implement nonpharmaceutical interventions

Function Definition: Coordinate with jurisdictional partners and stakeholders to implement and, if necessary, enforce the recommended NPI(s).

Tasks

Task 1: Implement NPIs in designated locations. Coordinate with jurisdictional officials to implement NPIs in priority locations, such as community settings where disease is circulating, isolation sites, or quarantine sites.

Task 2: Coordinate support services for NPIs. Assist community partners with coordinating support services, such as medical care, mental health services, and the provision of food and water, for individuals and communities targeted for NPI(s).

Task 3: Close locations and cancel events with mass gatherings. Implement voluntary or mandatory closure of specific locations or cancel large events in coordination with appropriate jurisdictional officials and other stakeholders.

Task 4: Restrict movement. Implement voluntary or mandatory restrictions on movement, as needed, in coordination with relevant jurisdictional officials, partners, and stakeholders.

Task 5: Manage and detain passengers at ports of entry. Coordinate with CDC's Division of Global Migration and Quarantine (quarantine station), port authorities, and jurisdictional officials to manage and detain passengers at ports of entry, as applicable to the incident, including security and law enforcement support, notification of family, and provision of food, shelter, water, and communication channels.

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Task 6: Ensure external decontamination of individuals. Screen, register, and conduct external decontamination of potentially exposed or contaminated individuals.

Task 7: Inform the public, responder agencies, and other partners of recommendations for NPIs. Provide education and appropriate messaging to the public, responder agencies, and other partners regarding the recommended NPIs.

Preparedness Resource Elements

P1: (Priority) Written agreements, such as contracts or MOUs, with partners to implement appropriate plans for NPIs, including provisions of support services, such as care for dependent children, notification of family, and provision of food, shelter, water, and communication channels, to individuals during isolation or quarantine scenarios.

(See Capability 1: Community Preparedness and Capability 10: Medical Surge)

P2: (Priority) Written agreements, such as contracts or MOUs, to provide mental/behavioral health services to individuals affected by NPIs, including services to address the access and functional needs of at-risk individuals who may be disproportionately impacted by a public health incident or event. Agreements may be established for services, which may include

- Mental/behavioral health services for specific populations when monitoring restriction of movement, such as isolation or quarantine, or other NPIs , such as social distancing and implementation of specialized hygiene requirements
- Mental/behavioral health services for families and dependents of those placed under mandatory restrictions
- Systems to provide mental/behavioral health services in person or via alternate communication methods, including phone, Internet, social media, teleconference, or other means

P3: (Priority) Procedures in place to separate and monitor cohorts of potentially exposed travelers from the general population at ports of entry.

Legal and regulatory considerations that apply to ports of entry may include

- State or local legal authorities for detention, quarantine, and conditional release of potentially exposed persons and isolation of ill persons
- Triggers for transfer of authority, such as from federal to state or local levels or vice versa
- Local and state port of entry Communicable Disease Response Plans, as described in the Code for Federal Regulations, 42 CFR, Parts 70 and 71
- Information sharing between CDC and state, local, tribal, and territorial public health authorities, including protection of sensitive information, such as protected health information

Resource and planning considerations may include

- Identification of personnel and other resources, including facilities and equipment, at or near ports of entry to be used for separation of cohorts
- Resources to address the needs of individuals for food, water, shelter, communications, and other resources
- Processes to supplement or surge resources
- Scalable plans to accommodate cohorts of various sizes in facilities
- Processes for transportation of cohorts to and security at pre-identified sites

(See Capability 13: Public Health Surveillance and Epidemiological Investigation)

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P4: Procedures in place to implement isolation or quarantine measures at designated locations. Procedures may include

- Timeframe for establishing supporting operations at designated locations
- MOUs or similar agreements with site owners for use of sites
- Written agreements for equipment needed at designated sites
- Triggers for transfer of authority, such as from federal to state or local levels or vice versa
- Pre-identified sites for housing cohorts to be isolated or placed under quarantine
- Environmental conversion of sites needed for intervention, such as converting rooms to negative pressure and establishing isolation rooms, dedicated patient care equipment, and separate areas for donning and doffing personal protective equipment (PPE)
- Processes to supplement and surge resources, such as reallocating resources or obtaining additional resources through mutual aid or other agreements
- Documentation of expenses for potential reimbursement at either the jurisdictional or federal level
- Returning the site to normal operation, including decontamination, managing medical waste, or sanitization, if needed
- Advance consideration of family or child care issues that may have an impact on the implementation of a quarantine order

P5: Procedures in place to support coordination of population monitoring and external decontamination of individuals. Procedures may include

- Screening based on incident-specific criteria determined by relevant radiological or chemical subject matter experts
- Registration of exposed or possibly exposed individuals, including name, address, contact information, and location at the time of the incident. Include responders and volunteers in this registration process, as needed
- Processes to coordinate with organizations trained in decontamination to establish external decontamination stations at designated sites and removing or storing contaminated materials
- Facilitating referrals or transfers of individuals to emergency housing (accessible housing as needed) and to immediate or follow-up medical care

(See Capability 14: Responder Safety and Health and Capability 15: Volunteer Management)

P6: Procedures in place to support evacuation or relocation of populations because of a nuclear emergency, as appropriate, based on the jurisdictional public health role.

P7: Templates and intervention-specific public educational materials that are modifiable at the time of the incident. Public education content may include

- How the public can access reliable information and sources for obtaining official information, such as hotlines, websites, radio station or public service announcements, social media, and television
- Populations recommended to seek medical care
- When and where the public should or should not seek medical care, if applicable
- How to prevent infection or exposure, including hand washing and other protective behaviors applicable to an incident

(See Capability 1: Community Preparedness, Capability 4: Emergency Public Information and Warning, Capability 7: Mass Care, and Capability 10: Medical Surge)

Return to Crosswalk

Skills and Training Resource Elements

S/T1: Personnel trained in supporting operations at an emergency community reception center (CRC). This training focuses on

- Locating CRCs based on the amount of space needed, the anticipated magnitude of the incident, and population needs of the community
- Establishing crowd management operations, including the development of process flow or triage procedures and the distribution of patient information sheets during population monitoring
- Using on-site equipment to monitor external contamination
- Planning for and addressing the access and functional needs of at-risk individuals who may be disproportionately impacted by a public health incident or event to allow them to access and move through the CRC
- Facilitating referrals of individuals experiencing psychological trauma to mental/behavioral health services
- Establishing and maintaining contacts with federal agencies for equipment, personnel, and expertise

S/T2: Personnel or agencies with legal expertise authorized to advise individuals on legal or regulatory aspects of NPIs. Ensure the appropriate legal guidance needed for interventions, such as quarantine, isolation, and mandatory orders to close events or order evacuations.

S/T3: Relevant personnel trained to understand decontamination procedures.

Function 4: Monitor nonpharmaceutical interventions

Function Definition: Monitor the implementation and effectiveness of interventions, adjust intervention methods and scope as the incident evolves, and determine the level or point at which interventions are no longer needed.

Tasks

Task 1: Assess implementation and effectiveness NPIs. Assess the effectiveness and uptake of NPIs using relevant data about the disease or exposure, such as the degree of transmission, contamination, infection, and severity of exposure, and monitor potential unintended or adverse effects of interventions.

Task 2: Provide updated information to partners related to the use of NPIs. Provide reports about the use of NPIs, as needed, to relevant agencies, partners, and stakeholders to inform continuous and timely decision making.

Task 3: Revise recommendations for NPIs. Update recommendations for NPIs as indicated by the incident, including increasing or decreasing frequency or implementing new interventions.

Task 4: Conduct after-action reviews of NPIs. Identify lessons learned related to NPI implementation within after-action reports (AARs) and develop and implement corresponding improvement plans (IPs).

Return to Crosswalk

Preparedness Resource Elements

P1: (Priority) Procedures in place, developed in consultation with appropriate public health officials, to monitor the effectiveness of NPIs based on surveillance data and other information. Procedures may include

- Methods for evaluating public understanding of information messages about NPIs
- Indicators of compliance with interventions, such as findings from on-site inspections and participation in active monitoring
- Tracking of environmental changes, such as wind direction, that may impact the need for or effectiveness of interventions
- Surveillance methods to monitor ongoing rates of transmission, contamination, or infection and severity of exposure, including
  - Case definitions
  - Contact investigations
  - Surveys
  - Epidemic curves
  - Reproductive ratios
- Systems to be used for electronic laboratory reporting (ELR), electronic case reporting (eCR), environmental monitoring, and other epidemiological reporting

(See Capability 4: Emergency Public Health Information and Warning and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P2: Procedures in place to describe how the public health agency will monitor cases or exposed persons with assistance from community partners. Procedures may include

- Sharing surveillance information between community partners and jurisdictional public health agencies
- Establishing a common operating picture between the jurisdictional public health agency and the health care system
- Following up with persons or households participating in NPI(s), which may involve registries, call lines, or periodic follow-up observations
- Protecting confidential information or personal identifiers, including secure receipt and storage of sensitive information

(See Capability 3: Emergency Operations Coordination, Capability 6: Information Sharing, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P3: Documented feedback related to intervention actions taken by local jurisdictions and community partners as part of the incident AAR and IP.

(See Capability 3: Emergency Operations Coordination)

P4: (Priority) Triggers and timeframes for ceasing NPIs.

(See Capability 3: Emergency Operations Coordination and Capability 13: Public Health Surveillance and Epidemiological Investigation)

Equipment and Technology Resource Elements

E/T1: Equipment to support collection and compilation of incident data, such as electronic communications and data storage equipment.

(See Capability 6: Information Sharing)

Return to Crosswalk

Capability 12: Public Health Laboratory Testing

Definition: Public health laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address actual or potential exposure to threat agents in multiple matrices, including clinical specimens and food, water, and other environmental samples. This capability supports passive and active surveillance when preparing for, responding to, and recovering from biological, chemical, and radiological (if a Radiological Laboratory Response Network is established) public health threats and emergencies.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Conduct laboratory testing and report results
- **Function 2:** Enhance laboratory communications and coordination
- **Function 3:** Support training and outreach

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Updates Laboratory Response Network (LRN) requirements
- Incorporates LRN-chemical requirements
- Prioritizes cooperation, coordination, and information sharing with LRN laboratories, other public laboratories, and jurisdictional sentinel laboratories

For the purposes of Capability 12, partners and stakeholders may include the following:

- civil support teams
- clinical laboratories
- emergency management agencies
- environmental health
- epidemiologists
- federal laboratory networks and member laboratories[11]
- first responders
- food safety
- health care providers
- jurisdictional sentinel laboratories[11]
- law enforcement
- LRNs
- non-laboratory response health care providers
- non-LRN public health
- poison control centers

[11] For example, the Food Emergency Response Network, National Animal Health Laboratory Network, and the Environmental Response Laboratory Network

Return to Crosswalk

Function 1: Conduct laboratory testing and report results

Function Definition: Perform or coordinate laboratory testing to detect, characterize, confirm, and report biological, chemical, radiological, and public health threats using established protocols and procedures. Testing may include clinical specimens and food, water, and other environmental samples.

Tasks

Task 1: Check in samples for specimen testing. Receive, record, and route specimen samples to ensure that the samples are received by the appropriate laboratory for testing and that the specimen information is populated in the laboratory information system.

Task 2: Conduct specimen sample testing. Test clinical specimens and food, water, and other environmental samples according to designated laboratory type and level in order to identify biological, chemical, or radiological threat agents.

Task 3: Report presumptive or confirmed laboratory results. Notify appropriate public health, public safety, and law enforcement officials of results using electronic messaging in appropriate formats with the ability to notify 24/7.

Task 4: Maintain plans for surge and continuity of operations. Establish and maintain the ability to implement continuity of operations (COOP) plans and surge plans for both the short term (days) and long term (weeks to months).

Preparedness Resource Elements

P1: (Priority) LRN for Biological Threats Preparedness (LRN-B) Reference laboratories with proficiency in LRN-B testing methods and the ability to accurately test for agents as defined in the LRN-B Standard Laboratory Checklist.

P2: (Priority) LRN for Chemical Threats Preparedness (LRN-C) member laboratories with LRN-C Quality Assurance Program "Qualified" status achieved through the successful participation in proficiency testing challenges. LRN-C core and additional methods are identified on the restricted access LRN website and updated annually.

P3: (Priority) LRN for Radiological Threats Preparedness (LRN-R) participating laboratories with LRN-R Quality Assurance Program "Qualified" status achieved through the successful participation in performance testing challenges, if LRN-R is established.

P4: Procedures in place for referring suspicious samples, such as samples from sentinel laboratories or first responders, to the laboratory jurisdictionally designated to receive them. Recommended procedures include those to safely package, document, and ship suspicious samples.

P5: (Priority) Procedures in place to test and report high-consequence samples from designated areas. If a jurisdiction has a high priority area (HPA), the associated LRN-B Reference laboratory must maintain the ability to ensure testing and results reporting of high-consequence samples from these designated areas within 24 hours of notification that testing is required.

P6: Procedures in place to ensure proper security and maintenance of records management systems.

(See Capability 6: Information Sharing)

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P7: (Priority) Procedures in place for data exchange with law enforcement, public safety, and other agencies with roles in responding to public health threats, as permitted by applicable laws, rules, and regulations. Procedures should address data security and prevent inappropriate or unauthorized disclosure of secure information. Procedures should detail the acceptable data exchange processes and list the order of priority for using each process.

(See Capability 6: Information Sharing)

P8: (Priority) Procedures in place for laboratory surge capacity based on best practices and models available through LRN programs. Recommended procedures may include

- Procedures to secure and deploy surge personnel, equipment, and facility resources for short-term (days) and long-term (weeks to months) response efforts
- Procedures for triage and management of surge testing, which may include
  - Referral of samples to other LRN laboratories within or outside the jurisdiction using mechanisms and guidance made available by the LRN
  - Prioritization of testing based upon sample type
  - Prioritization of testing based upon risk or threat assessment

(See Capability 10: Medical Surge)

P9: (Priority) Procedures in place for a laboratory COOP plan to ensure the ability to conduct ongoing testing on routine and emerging public health threats. COOP plans should include

- Procedures for regular maintenance of redundant testing supplies
- Processes to designate alternate testing facilities for short-term duration in case of localized infrastructure failure
- Agreements with other agencies to take over critical testing, as appropriate
- Procedures to address personnel shortages
- Procedures to address equipment failures
- Procedures to address operational loss of laboratory facilities

P10: Notification procedures to detail how laboratory results suggestive of an outbreak or exposure will be reported or messaged to appropriate health investigation partners using secure contact methods per LRN notification policies or laboratory-specific policies. Notification procedures should include appropriate messaging timeframes per LRN data messaging and other laboratory-specific policies.

(See LRN Notification and Data Messaging Policies, Capability 3: Emergency Operations Coordination, and Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: (Priority) LRN-B Standard and Advanced Reference laboratories must meet all requirements of the LRN-B Standard Reference laboratories as listed in the Checklist of Laboratory Requirements for LRN-B Member Standard Level Reference Laboratories located on the restricted access LRN website. In addition, Advanced Reference laboratories must support CDC's LRN-B program office and the network in activities that may include

- Deployment of new technologies and specialized methods
- Evaluation of new technologies

[12] LRN Notification and Data Messaging Policies are located on the restricted access LRN website.

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- Engagement in multicenter validation studies
- Participation in priority partnership exercises
- Provision of high throughput surge testing capacity
- Assistance with quality initiatives, including network training programs and proficiency testing remediation
- Maintenance of registration with Federal Select Agent Program
- Provision of resources to ship isolates to CDC for further clarification

S/T2: (Priority) All LRN-B, LRN-C, and LRN-R (if LRN-R is established) laboratories able to pass LRN proficiency testing, as required by the respective LRN program.

S/T3: LRN-B Advanced Reference laboratories and other Reference laboratories capable of performing LRN-B approved assays and participate in technical meetings, as necessary.

S/T4: Personnel who perform LRN protocols trained in LRN methods and able to demonstrate proficiency and competency in compliance with applicable regulations, such as Clinical Laboratory Improvement Amendments (CLIA) from regulatory agencies, such as the Centers for Medicare and Medicaid Services (CMS), College of American Pathologists (CAP), or other regulatory equivalent. Documentation should include training date(s) and manner of training delivery, such as formal or "train the trainer."

S/T5: Personnel from LRN-C laboratories who participate in the LRN-C biannual technical meeting, formerly known as Level 1 surge capacity meeting.

S/T6: Personnel who regularly perform LRN testing, including those identified for surge capacity, trained annually in appropriate safety procedures. Documentation should include training date(s) and manner of delivery, such as formal training or "train the trainer."

S/T7: Personnel trained on emergency operations and incident management system.

S/T8: (Priority) All laboratories accredited by an appropriate accreditation body, such as CAP, CMS, or the International Organization for Standardization.

Equipment and Technology Resource Elements

E/T1: (Priority) At least one LRN-B approved instrument for rapid nucleic-acid detection and one LRN-B approved instrument for antigen-based detection owned and maintained by each LRN-B Reference laboratory. Instruments are listed in the current equipment list, which is updated annually on the restricted access LRN website. Preventative maintenance and service agreements must be provided for all equipment listed on the LRN-B equipment list.

E/T2: (Priority) Laboratory equipment and instruments serviced, inspected, and certified. The following should be established and maintained in coordination with public health emergency management

- Preventative maintenance contracts and service agreements for equipment and instruments described within applicable LRN protocols, procedures, and methods
- Inspection and certification of equipment and instruments used by the LRN-B and LRN-C according to manufacturers' specifications

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E/T3: (Priority) LRN-C Level 2 laboratories that own and maintain at least one instrument listed on the LRN-C equipment list. LRN-C Level 1 laboratories that own and maintain at least two instruments each listed on the LRN-C equipment list. Preventative maintenance and service agreements must be provided for all equipment listed on the LRN-C equipment list.

E/T4: (Priority) Reagent inventory and laboratory supplies maintained to levels adequate to perform routine testing, with plans for obtaining additional reagents or supplies during a surge event, establish priority access rights with suppliers, if possible.

E/T5: (Priority) Laboratory Information Management System (LIMS) that is routinely updated and maintained in order to send testing data to CDC according to CDC-defined standards. Procedures and resources needed to use and maintain the LIMS may include

- Protocols, including timelines, to send and receive data from local LIMS to CDC and other partners
- Local codes mapped to federal standards, such as Data Integration Requirements for LRN-B and LRN-C
- Dedicated information technology (IT) support personnel to maintain and update LIMS or contractual agreements with LIMS vendors that are familiar with national standards, such as LIMS integration, Public Health Laboratory Interoperability Project, and industry standards, such as logical observation identities, names, and codes; systematized nomenclature of medicine; Health Level 7 (HL7), to configure the LIMS
- Periodic validation of LIMS functionality and message structure
- Alternate data sharing strategies in the event of a failure in the LIMS or CDC-provided systems for LRN data exchange

E/T6: Representative(s) from both the LRN-B and LRN-C laboratories in the jurisdiction with current Secure Access Management Services (SAMS) access to electronic data exchange systems.

E/T7: At least one working computer able to access LRN and partner electronic data exchange systems.

E/T8: Access to a mechanism (automated, electronic, or paper-based) for messaging results to LRN-B, LRN-C, and LRN-R (if LRN-R is established).

E/T9: Access to an operational and biosafety level 3 (BSL-3) laboratory either on site or through a memorandum of understanding (MOU) or other formalized agreement.

Function 2: Enhance laboratory communications and coordination

Function Definition: Ensure timely laboratory results reporting to stakeholders to support determination of the cause or origin, definitively characterize the threat, and inform deployment of appropriate countermeasures.

Tasks

Task 1: Ensure effective information exchange. Ensure timely exchange of laboratory information and data with laboratories, laboratory network partners, and other stakeholders. Provide unique identifiers that support linking laboratory data to epidemiologic data.

Task 2: Coordinate with preparedness partners to support public health investigations. Use laboratory testing to coordinate public health investigations with preparedness and response partners, as required by the incident.

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Task 3: Provide investigative consultation and technical assistance. Support jurisdictional public health agencies, first responders, law enforcement, and other health investigation partners with sample collection, management, and safety.

Preparedness Resource Elements

P1: (Priority) Procedures in place to facilitate cooperation, coordination, and information sharing with and among stakeholders, which may include

- LRN-B, LRN-C, and LRN-R (if LRN-R is established) member laboratories within the jurisdiction, including jurisdictional sentinel laboratories, and non-LRN public health laboratories, such as those identified in COOP planning for example, environmental, agricultural, veterinary, and local public health
- Federal laboratory networks and member laboratories for example, the Food Emergency Response Network, National Animal Health Laboratory Network, and the Environmental Response Laboratory Network
- Poison control centers that can serve as supporting resources for exposure incidents
- Health care providers or clinical laboratories that may be packaging and shipping samples and, subsequently, receiving sample results during a response
- Epidemiologists who interface with hospitals, public health agencies, and laboratories

(See Capability 6: Information Sharing, Capability 7: Mass Care, Capability 10: Medical Surge, and Capability 13: Public Health Surveillance and Epidemiological Investigation)

P2: (Priority) Procedures or guidelines in place to coordinate with relevant stakeholders in specific incidents. Procedures may include

- Procedures for communicating with sentinel laboratories in the event of a public health incident
- Policies developed in coordination with jurisdictional stakeholders for handling biological, chemical, radiological, nuclear, and explosive incidents
- Coordination with first responders who may initially identify overt exposure incidents
- Coordination with Civil Support Teams (CSTs) to establish partnerships between CSTs and the public health laboratories with respect to field analysis of unknown samples
- Coordination with local law enforcement and Federal Bureau of Investigation (FBI) field offices for screening and triage procedures for environmental samples, such as biological, chemical, radiological, and explosive materials
- Coordination with emergency management officials and other relevant entities, such as fusion centers supporting an emergency response, including incidents when the Emergency Management Assistance Compact (EMAC) is activated
- Updated contact list for state, local, tribal, and territorial law enforcement and first responder units, such as HazMat and poison control center, who are approved to perform screening and triage procedures on unknown samples

(See Capability 3: Emergency Operations Coordination and Capability 14: Responder Safety and Health)

P3: Designated individual(s) responsible for coordinating emergency response activities, such as personnel safety, sample collection, methods training, plans, guidance, and outreach to sentinel laboratories and first responder communities.

(For additional guidance on chain of custody procedures, see the restricted access LRN website)

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P4: Updated contact list for LRN-B laboratories (sentinel and public health laboratories), LRN-C laboratories, and LRN-R laboratories (if LRN-R is established) in the jurisdiction as well as other jurisdictional laboratories that collaborate with the public health agency.

(See Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: Personnel with awareness of current national policy and leading practices for biological, chemical, and radiological (if LRN-R is established) threat preparedness attained through regular participation in LRN national meetings, if available.

S/T2: Public health laboratory managers and directors, meaning those responsible for overseeing laboratory activities, who have completed the CDC/FBI Joint Criminal Epidemiology Investigations workshop, as needed. Coordinate with FBI field office to complete this workshop.

Function 3: Support training and outreach

Function Definition: Perform outreach, facilitate access to training, and maintain applicable protocols for sample collection, handling, packaging, processing, shipping, transport, receipt, storage, retrieval, and disposal.

Tasks

Task 1: **Facilitate access to training for handling, packaging, and shipping samples.** Ensure established International Air Transport Association (IATA), U.S. Department of Transportation (DOT), and other laboratory-specific protocols are followed when managing laboratory samples.

Task 2: **Maintain chain of custody procedures.** Ensure chain of custody requirements are maintained throughout the sample management process.

Task 3: **Support training, exercising, and laboratory participation in preparedness and response operations.** Provide or facilitate access to training and exercises for relevant stakeholders.

Preparedness Resource Elements

P1: **(Priority)** Procedures in place for sample collection, triage, labeling, packaging, shipping, transport, handling, storage, and disposal. Sample collection procedures should include 24/7 contact information and submission criteria in accordance with applicable requirements, such as requirements from the IATA, DOT, and Federal Select Agent Program.

P2: **(Priority)** Transportation security procedures in place that may include

- Select agent and toxin regulations (if applicable)
- Biosafety or biosecurity plan (applicable even if laboratory is not select agent registered)
- Chemical hygiene plan
- LRN-R: Radiation Safety and Security Plan (if LRN-R is established)
- Other protocols, as needed, to ensure adherence to applicable federal, state, local, tribal, and territorial regulations related to transport of clinical specimens and hazardous and radiological materials

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P3: Procedures in place for chain of custody that meet the minimum sample control evidentiary procedures established by federal agencies and partners, such as the FBI, LRN, and Integrated Consortium of Laboratory Networks.

P4: A designated biological safety officer or official (BSO) for technical support and guidance regarding internal laboratory activities and technical assistance to strengthen biosafety in sentinel clinical laboratories.

P5: Procedures in place to ensure adequate supplies for packaging and shipping are available 24/7, including procedures to rapidly procure additional supplies when needed.

Skills and Training Resource Elements

S/T1: Ability to provide packaging and shipping training or information on the availability of packaging and shipping training in DOT regulations or IATA guidance for public health laboratory personnel and sentinel laboratories.

S/T2: (Priority) Laboratory personnel certified in a shipping and packaging program that meets national and state or territorial requirements.

S/T3: Biological, chemical, and radiological (if LRN-R is established) threat laboratory personnel trained annually on chain of custody procedures. Documentation should include training date(s) and manner of delivery, such as formal training or "train the trainer."

S/T4: Laboratory personnel trained annually in safety protocols for handling samples being prepared for shipment. Documentation should include training date and manner of delivery, such as formal training or "train the trainer."

S/T5: Laboratory adherence to appropriate regulatory requirements that may include

- A valid select agent registration number (LRN-B Advanced Reference laboratories only). Standard Reference laboratories are encouraged, but not required, to maintain select agent registration
- Valid shipping permit(s) from the U.S. Department of Agriculture, Animal and Plant Health Inspection Service, and Veterinary Services, as necessary
- License(s) from the Nuclear Regulatory Commission or state entities as required (LRN-R laboratories only, if network is established)

S/T6: Public health laboratory designee(s) trained, as needed, to advise on proper collection, packaging, labeling, shipping, and chain of custody procedures for shipping samples.

S/T7: (Priority) Laboratories trained in partnership with public health emergency management programs to support laboratory preparedness and response operations. Activities may include

- Education, training, and exercising to advance knowledge and skills necessary to perform LRN duties. Trainings may be provided by CDC, the Association of Public Health Laboratories (APHL), or other respected entities with appropriate expertise and may include
  - Rule-out and refer for biological threat agents
  - Packaging and shipping of infectious substances
  - Specimen collection and shipping for chemical and radiological analysis
- Participation in public health exercises and drills, including those required for LRN membership and others necessary for emergency preparedness and response
- Moot court training

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Capability 13: Public Health Surveillance and Epidemiological Investigation

Definition: Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes. It also includes the ability to expand these systems and processes in response to incidents of public health significance.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Conduct or support public health surveillance
- **Function 2:** Conduct public health and epidemiological investigations
- **Function 3:** Recommend, monitor, and analyze mitigation actions
- **Function 4:** Improve public health surveillance and epidemiological investigation systems

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Increases alignment to public health surveillance and data strategies
- Strengthens surveillance systems for persons in isolation or quarantine and persons placed under monitoring and movement protocols
- Emphasizes syndromic surveillance and data collection to improve situational awareness and responsiveness to hazardous events and disease outbreaks, for example, participation in the CDC's National Syndromic Surveillance Program BioSense Platform

For the purposes of Capability 13, partners and stakeholders may include the following:

- agricultural agencies
- clinical laboratories
- clinicians
- community health centers
- environmental health agencies
- first responders
- food safety agencies
- health care organizations
- law enforcement agencies
- medical examiner or coroner offices
- poison control centers
- public health officials

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Function 1: Conduct or support public health surveillance

Function Definition: Conduct or support ongoing systematic collection, analysis, interpretation, and management of public health-related data to effectively detect, verify, characterize, and manage a threat, hazard, risk, or incident of public health concern throughout and following an incident.

Tasks

Task 1: Engage stakeholders to support public health surveillance and investigation. Coordinate activities with jurisdictional laboratories, partners, and stakeholders who can provide public health-related surveillance data to support routine and emergency responses requiring surveillance and epidemiological investigation.

Task 2: Conduct or support routine and incident-specific surveillance. Use data to conduct and support health-related surveillance. Data sources for surveillance may include

- Case findings
- Hospital discharge abstracts
- Population-based surveys
- Pre-hospital emergency medical services records
- Registries
- Reportable disease surveillance
- Syndromic surveillance
- Vital records
- Other inputs

Task 3: Share surveillance findings. Share surveillance data and communicate statistical analyses of surveillance data to the jurisdictional public health agency and other applicable jurisdictional leaders, health care providers, and data providers to assist with the prompt identification of potentially affected populations at risk for adverse health outcomes and enable rapid decision making during a natural or human-caused public health threat or incident.

Task 4: Maintain and improve surveillance systems. Maintain, assess, and strengthen surveillance systems, and continuously support bi-directional information exchange to respond promptly to public health threats, hazards, and incidents.

Preparedness Resource Elements

P1: (Priority) Legal and procedural frameworks for jurisdiction personnel involved in surveillance and epidemiology to support mandated and voluntary information exchange with a wide variety of community partners and stakeholders, including tribal communities and populations at risk to be disproportionately impacted by the incident.

P2: (Priority) Procedures in place to gather and analyze data on a broad range of health indicators, such as indicators identified in novel or emerging public health threats, case definitions, and World Health Organization (WHO) public health emergencies of international concern (PHEIC) declarations.

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Surveillance activities, ranging from passive to active, may include

- Reportable condition surveillance for conditions mandated for inclusion in case reporting to public health agencies, such as monitoring travelers from high-risk areas. Reportable condition surveillance activities may include
  - Electronic laboratory reporting (ELR)
  - Electronic case reporting (eCR) for reportable conditions from clinical laboratories and health care providers
  - Other notifiable disease and injury surveillance, such as non-electronic reporting and astute clinician notification
- Environmental health surveillance
- Incident-specific surveillance (sentinel surveillance)
- Syndromic surveillance to improve situational awareness, which may include
  - CDC's National Syndromic Surveillance Program BioSense Platform
  - Surveillance systems for pregnancy, infants, and birth defects
  - State or locally developed syndromic surveillance systems
- Vital statistics surveillance, including birth and death registration
- Animal-related surveillance and vector control

Data to gather and analyze may include

- Active case finding data, such as health care logs and record reviews
- Background or baseline disease data
- Chemical exposure assessment data, such as data from the Assessment of Chemical Exposure (ACE) Program
- Environmental data, such as air quality, ground or surface water, water quality testing, and soil or sediment data
- HazMat data, such as hazardous material spills
- Hospital and other health care services data, such as discharge abstracts
- Immunization data
- Law enforcement data
- Mental/behavioral health data
- Poison control center data
- Population-based survey data
- Radiological exposure and dose reconstruction data
- Responder monitoring data
- Unusual incident of unexplained morbidity or mortality in humans or animals data
- Workers compensation claims data
- Work-related injuries and illnesses data, such as Occupational Safety and Health Administration (OSHA) 300 logs
- Zoonotic disease or animal data

(See Capability 6: Information Sharing, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

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P3: (Priority) Procedures specific to public health surveillance in place to access and share health-related information while following jurisdictional requirements and federal laws for protecting personal health information and personally identifiable information, such as institutional security and confidentiality policies.

(See Capability 6: Information Sharing and Capability 12: Public Health Laboratory Testing)

P4: (Priority) Procedures in place for the jurisdictional public health agency to access, collect, analyze, interpret, and respond to reports of potential public health threats or incidents.

(See Capability 3: Emergency Operations Coordination)

P5: (Priority) Regularly updated and verified list(s) of identified stakeholders who will share, receive, and distribute surveillance reports.

(See Capability 6: Information Sharing)

P6: (Priority) Procedures in place to notify CDC of cases of diseases or conditions included in the National Notifiable Disease Surveillance System (NNDSS). Procedures also include immediate notifications concerning PHEICs.

(See Capability 6: Information Sharing)

P7: Procedures in place to ensure the electronic exchange of personal health information meets applicable patient privacy-related laws, standards, and jurisdictional requirements. Laws, standards, and requirements may include

- Health Insurance Portability and Accountability Act (HIPAA)
- Health Information Technology for Economic and Clinical Health Act
- Standards from the National Institute of Standards and Technology and the Office of the National Coordinator for Health Information Technology of the U.S. Department of Health and Human Services (HHS)
- Message mapping guides for Health Level 7 (HL7) case notifications

(See Capability 6: Information Sharing)

P8: Procedures in place to assess and improve systems to ensure continuity of surveillance operations if primary surveillance and detection systems are disrupted for example, due to power failure or compromise of electronic infrastructure.

Skills and Training Resource Elements

S/T1: (Priority) Public health personnel who participate in data collection, analysis, and reporting to support surveillance investigations trained, at a minimum, in the Tier 1 level Applied Epidemiology Competencies (AEC). Personnel skilled and able to use software systems to support data collection, reporting, management, and analysis. Consideration should be given to

- Securing assistance (through coordination with academic institutions or state-level personnel) from individuals with Tier 2 level AECs when creating a new system or updating an existing system
- The Public Health Informatics Institute Applied Public Health Informatics Competency Model

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Equipment and Technology Resource Elements

E/T1: Systems to accept, process, analyze, exchange, and share surveillance and epidemiological data across multiple disciplines. These systems also may track and monitor known cases and exposed persons through disposition to enable short- and long-term follow-up. Systems may include

- ELR systems
- Electronic laboratory test order and reporting (ETOR) systems
- eCR systems
- Electronic death registration systems (EDRS)
- Syndromic surveillance systems
- Outbreak management systems
- System for tracking investigation or monitoring of potential contacts to cases, meaning systems that track isolated and quarantined persons for direct active monitoring
- Immunization registries or immunization information systems
- Emergency management information sharing systems, such as WebEOC
- Emergency Responder Health Monitoring and Surveillance™ (ERHMS™) and occupational registries
- Zoonotic disease surveillance systems
- HazMat reporting systems
- National Poison Data System (NPDS)
- Environmental public health tracking systems (EPHT)

(See Capability 6: Information Sharing, Capability 14: Responder Safety and Health, and Capability 15: Volunteer Management)

E/T2: Systems to ensure the electronic management and exchange of information, including laboratory test orders, samples, results, and other information, with jurisdictional partners and stakeholders. Systems should be capable of interfacing with pertinent databases and meet necessary computing power and technical specifications.

Function 2: Conduct public health and epidemiological investigations

Function Definition: Identify the source of a case or outbreak of disease, injury, or exposure and the associated determinants in a population, including time, place, person, vital status, or other indices, to report results and findings to cross-disciplinary jurisdictional and federal partners and stakeholders.

Tasks

Task 1: Conduct public health and epidemiological investigations. Investigate diseases, injuries, and exposures in response to natural or human-caused threats or incidents in collaboration with jurisdictional stakeholders.

Task 2: Provide support to local public health and epidemiological investigations. Provide clinical and public health-related consultations to support public health agency investigations.

Task 3: Share public health and epidemiological investigation findings. Report investigation results to impacted communities and jurisdictional and federal partners, as applicable.

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Preparedness Resource Elements

P1: (Priority) Templates for outbreak or multiple exposure investigation reports that may include

- Context and background—Information to characterize the incident may include
  - Population(s) affected, including the estimated number of persons exposed, number of persons affected, and relevant demographic information, such as age, disability status, chronic health condition(s), and pregnancy or lactation status
  - Location(s), such as setting or venue
  - Geographical area(s) involved
  - Timeframe(s)
  - Suspected or known etiology
  - Jurisdictional risks
- Initiation of investigation—Information regarding receipt of the case report or notification and initiation of the investigation may include
  - Date and time initial notification was received by the agency
  - Date and time investigation was initiated by the agency
- Investigation methods—Epidemiological or other investigative methods employed may include
  - Initial investigative activity, such as verified laboratory results
  - Interviews
  - Case definitions (as applicable)
  - Data collection and analysis methods , such as case-finding, cohort or case-control studies, and environmental data
  - Disaster epidemiology tools, such as the Community Assessment for Public Health Emergency Response (CASPER) toolkit and the Assessment of Chemical Exposures (ACE) Program toolkit
  - Data presentation and visualization, such as disaster epidemiology tools, epidemic curves, attack rate tables, and maps
  - Questionnaires
  - Exposure assessments and classifications
  - Radiation dose assessment or reconstruction
  - Review reports developed by first responders, laboratory testing of environmental samples, reviews of environmental testing records, and industrial hygiene assessments
- Investigation findings and results—Applicable investigation results may include
  - Epidemiological results
  - Exposure assessment results
  - Laboratory results
  - Biomonitoring results
  - Clinical results
  - Other analytic findings
  - Record(s) of case notification(s)
- Discussion and conclusions—Analysis and interpretation of investigation results and conclusions drawn as a result of performing the investigation

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- Recommendations—Suggested approaches for controlling spread of disease or preventing future outbreaks or preventing or mitigating the effects of an acute environmental hazard
- Key investigators and report authors—Names and titles to facilitate communication with partners, clinicians, and other stakeholders

P2: Procedures in place to support jurisdictional methods for conducting investigations of public health, environmental, and occupational threats, incidents, and hazards. Investigation considerations may include

- Elements or instances that trigger the start of an investigation, including the initiation date and time of investigation
- Identification of population(s) at risk to be disproportionately impacted by an incident
- Identification of individual case or exposure status (confirmed, probable, and suspected cases)
- Identification of jurisdictional risks, including jurisdictional risk assessment findings
- Identification of exposed persons and contact tracing
- Determination of source, exposure, and, as applicable, transmission mapping of identified and suspect cases, injuries, or exposures within the jurisdiction

P3: Procedures in place to establish partnerships, conduct investigations, and share information with other governmental agencies, partners, and organizations to support populations at risk of adverse health outcomes as a result of the incident.

P4: Written agreements, such as contracts or memoranda of understanding (MOUs), to authorize joint investigations and information exchange and to clarify agency roles between public health and other partners and stakeholders.

P5: Laws, statutes, policies, and procedures that ensure jurisdictional public health agencies have the authority to collect and share a uniform set of jurisdictional health-related data associated with diseases, exposures, or injury conditions of public health importance.

(See Capability 6: Information Sharing)

Skills and Training Resource Elements

S/T1: Personnel trained to manage and monitor routine surveillance and epidemiological investigation systems at the jurisdictional level and support surge requirements in response to natural and human-caused threats or incidents. Personnel skilled and able to use software systems to support data collection, reporting, management, and analysis. Specific jurisdictional needs may include

- Personnel, including surge support personnel with Tier 1 level AECs
- Access to individuals, such as academic or state-level personnel, with Tier 2 level AECs when creating a new or updating an existing system

Equipment and Technology Resource Elements

E/T1: Public health surveillance systems to monitor health status and exposure risks of individuals and groups, including criteria for reporting health events and criteria or processes for maintaining or contributing to population health surveillance registries.

E/T2: Information systems to aid in the development of public health investigation reports using available and relevant information, such as results from clinical, environmental, or forensic samples may include

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- Databases or registries with the capacity to both receive and transmit data cross-jurisdictionally using standards-based electronic messaging that adheres to relevant HHS standards for Certified Electronic Health Records, Meaningful Use, and other interoperability standards
- Databases and registries that include protocols to protect personal health information in conformity with jurisdictional requirements and federal law, such as privacy and cybersecurity policies

(See Capability 6: Information Sharing)

Function 3: Recommend, monitor, and analyze mitigation actions

Function Definition: Recommend, implement, and support public health interventions that contribute to the mitigation of a threat, hazard, risk, or incident, and monitor intervention effectiveness.

Tasks

Task 1: Identify public health guidance and recommendations. Determine appropriate clinical, epidemiological, and environmental-related public health actions to mitigate threats, hazards, risks, or incidents based on current public health science-based standards.

Task 2: Share appropriate public health guidance and recommendations. Communicate and coordinate guidance and recommendations with public health officials, partners, and stakeholders to support decision-making related to mitigation actions.

Task 3: Monitor and assess public health interventions. Evaluate public health mitigation actions throughout the duration of the public health response and recommend additional mitigation measures as appropriate.

Preparedness Resource Elements

P1: (Priority) Procedures in place, developed in consultation with appropriate public health officials, to initiate and sustain surveillance, exposure containment, control, and mitigation actions, such as embargo, access restrictions, and isolation and quarantine in response to public health threats, hazards, risks and incidents. Procedures may include

- Case definitions
- Contact investigations
- Clinical management of potential or actual cases
- Provision of medical countermeasures
- Processes for exercising relevant legal authorities
- Provision of essential goods and services for isolated or quarantined persons
- Consultation with the Council of State and Territorial Epidemiologists (CSTE)

(See Capability 1: Community Preparedness, Capability 6: Information Sharing, Capability 8: Medical Countermeasure Dispensing and Administration, and Capability 11: Nonpharmaceutical Interventions)

P2: Procedures in place to use health-related data and statistics from partners, stakeholders, and jurisdictional public health agency programs that support recommendations for populations at higher risk for adverse outcomes during a natural or human-caused threat, hazard, risk, or incident.

(See Capability 1: Community Preparedness and Capability 6: Information Sharing)

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P3: Procedures in place to track mitigation actions, monitor performance, and document and share outcomes using data instruments, such as data reports or statistical summaries consistent with recommended science-based standards and sources, which include

- Control of Communicable Diseases Manual
- Epidemic Information Exchange (Epi-X)
- Health Alert Network (HAN) alerts
- Morbidity and Mortality Weekly Report
- Red Book of Infectious Diseases
- State or CDC incident reports/annexes

(See Capability 2: Community Recovery, Capability 5: Fatality Management, Capability 7: Mass Care, Capability 8: Medical Countermeasure Dispensing and Administration, Capability 11: Nonpharmaceutical Interventions, and Capability 14: Responder Safety and Health)

Skills and Training Resource Elements

S/T1: Personnel trained to conduct epidemiological investigations, including radiation assessment and monitoring, public health informatics, and public health information systems. CDC recommends that personnel are trained on the specific information systems used within their jurisdiction.

(See Capability 1: Community Preparedness)

S/T2: Personnel trained on Homeland Security Exercise and Evaluation Program (HSEEP) processes for developing after-action reports (AARs) and improvement plans (IPs).

Function 4: Improve public health surveillance and epidemiological investigation systems

Function Definition: Assess internal agency surveillance and epidemiologic investigation systems and implement quality improvement measures within jurisdictional public health agency control.

Tasks

Task 1: Evaluate effectiveness of public health surveillance and epidemiological investigation processes and systems. Evaluate surveillance and epidemiological investigation outcomes to identify deficiencies encountered during responses to public health threats and incidents and recommend opportunities for improvement.

Task 2: Identify and prioritize corrective actions. Conduct post-incident or post-exercise agency evaluation meetings with response participants and relevant partners and stakeholders to identify procedures and organizational opportunities for improvement requiring corrective action.

Task 3: Establish an after-action process, share after-action report(s) and improvement plan(s), and implement and monitor corrective actions. Obtain feedback from after-action conferences, hot washes, and incident debriefings. Develop and share AARs and IPs, and implement corrective actions.

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Preparedness Resource Elements

P1: (Priority) Procedures in place to assess jurisdictional response effectiveness with local public health agencies, data submitters, affected populations, and other key partners and stakeholders after the acute phase of a threat or incident. Recommended procedures may include

- Hot washes to effectively communicate response strengths and opportunities for improvement
- After-action processes, including completing AARs and IPs, and committees to effectively identify corrective actions
- Venues, such as town hall meetings to inform affected populations and other stakeholders
- Presentation and publication of epidemiologic investigations to contribute to the scientific body of evidence and improve knowledge of best practices and lessons learned

(See Capability 3: Emergency Operations Coordination)

P2: (Priority) Procedures in place to communicate AAR and IP findings to data submitters and other key partners and stakeholders, including groups representing affected populations, to implement identified corrective actions.

Skills and Training Resource Elements

S/T1: Personnel trained on quality improvement processes and techniques.

S/T2: Personnel trained on HSEEP AAR and IP guidelines.

(See Capability 3: Emergency Operations Coordination)

S/T3: Personnel trained to meet public health informatician competencies, as defined in CDC's Competencies for Public Health Informaticians, to contribute to information sourcing, use, and re-use for surveillance and epidemiologic analysis.

Equipment and Technology Resource Elements

E/T1: Electronic and non-electronic tools and methods for data collection, management, analysis, and sharing.

E/T2: Systems to track implementation and impact of corrective actions identified within AARs and IPs.

(See Capability 3: Emergency Operations Coordination)

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Capability 14: Responder Safety and Health

Definition: Responder safety and health is the ability to protect public health and other emergency responders during pre-deployment, deployment, and post-deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Identify responder safety and health risks
- **Function 2:** Identify and support risk-specific responder safety and health training
- **Function 3:** Monitor responder safety and health during and after incident response

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Incorporates the need to securely manage responder data
- Improves responder on-site management, tracking, in-processing, and out-processing
- Reprioritizes hierarchy of control and promotes the alignment of responder safety and health control measures for example, personal protective equipment (PPE), with jurisdictional risk assessment findings

For the purposes of Capability 14, partners and stakeholders may include the following:

- agriculture agencies
- emergency management agencies
- emergency responders[12]
- environmental health agencies
- environmental protection agencies
- health care agencies
- immunization programs
- incident safety officers
- mental/behavioral health providers
- occupational health subject matter experts
- occupational safety and health agencies
- public health agencies
- responder representatives
- social services
- state radiation control programs
- state epidemiology and communicable disease programs
- veterinary public health programs
- volunteer organizations
- wildlife agencies

[13] For example, contractors, volunteers, emergency medical services (EMS), law enforcement, fire departments, hospital and medical services personnel

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Function 1: Identify responder safety and health risks

Function Definition: Identify and prioritize responder safety and health risks, and determine the protection and control measures, medical services, including the provision of medical countermeasures, and mental/behavioral health support services necessary to protect and support responders.

Tasks

Task 1: Identify and prioritize safety and health risks. In conjunction with partner agencies, identify and prioritize the potential medical, environmental, and mental/behavioral health risks responders may encounter during an incident with public health consequences based on jurisdictional risk assessment findings.

Task 2: Identify, prioritize, and recommend protection and control measures, medical services, and mental/behavioral health support services for responders. Use a hierarchical approach in coordination with partners and stakeholders to identify, prioritize, and recommend protection and control measures, medical countermeasures, such as vaccinations, mental/behavioral health support services, and other resources to protect and support incident responders.

Task 3: Develop or refine incident safety plan. Use identified safety and health recommendations to develop or refine incident safety plan.

Task 4: Support responder eligibility confirmation. Provide recommendations and guidance to support pre-incident screening and verification of responder credentials, training, and health status, such as vaccinations, physical fitness, and mental health, to ensure suitability for deployment role.

Preparedness Resource Elements

P1: (Priority) Safety and health risk scenarios for public health responders, identified in consultation with partners and coordinating agencies. Scenario characteristics to consider before, during, and after an incident or event may include

- Exposure limits or injury risks necessitating a response
- Job-specific worker safety guides to address risks and hazards from radiation, heat, fire, infectious disease vectors and exposures, infrastructure damage resulting in hazardous material release, and other sources
- Potential for medical and mental/behavioral health assessments during and after the event
- Health care facilities
- PPE or other protective actions, behaviors, or activities required to execute potential response assignments

P2: (Priority) Defined public health agency roles and responsibilities for responder safety and health, such as conducting public health assessments, potable water inspections, field interviews, and points of dispensing staffing, related to identified jurisdictional risks established in conjunction with partner agencies.

P3: (Priority) Incident safety plans, such as site safety and control plan and medical plan (ICS 206 and 208) that include clear and concise statements for safety message(s), priorities, and key command emphasis, decisions, and directions. Plans should include mutual aid agreements (or similar agreements)

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to access and provide backup equipment for incident response, including intra- and inter-jurisdictional sources of additional equipment and personal protective resources.

(See Capability 3: Emergency Operations Coordination and Capability 9: Medical Materiel Management and Distribution)

P4: (Priority) Procedures in place to determine responder eligibility for deployment based on medical readiness, physical and mental/behavioral health screenings, background checks, and verification of credentials and certifications. Conduct additional screening according to the nature of the work and identified individual risk factors. Factors to consider in screenings and background checks may include

- Medical health, such as pre-existing conditions, immunization status, and medications
- Physical fitness
- Mental/behavioral health
- Criminal records, such as sexual offender registry

(See Capability 15: Volunteer Management)

P5: (Priority) PPE recommendations for responders, including public health responders, developed in conjunction with partner agencies and risk-specific subject matter experts, such as physicists within radiation control programs.

Skills and Training Resource Elements

S/T1: Public health personnel who fill the role of Incident Safety Officer trained to perform core functions, such as coordination, communications, resource dispatch, and information collection, analysis, and dissemination. Recommended trainings may include

- National Incident Management System (NIMS) ICS-300 and ICS-400 courses
- NIMS ICS All-Hazards Position Specific Safety Officer (E/L 954)
- FEMA Safety Orientation (IS-35.18)

S/T2: Personnel trained to use various types of PPE and decontamination procedures when responding to chemical, biological, and radiological incidents.

S/T3: Personnel trained on jurisdictional systems for population monitoring to identify risks and recommendations for PPE. Training is recommended for various responder types, including environmental health personnel, preparedness personnel, epidemiologists, and other disciplines, such as HazMat Teams who will participate in planning and identifying responder risks.

Equipment and Technology Resource Elements

E/T1: Responder registration system that is scalable, secure, and compliant with NIMS.

E/T2: Information technology and cybersecurity safeguards and practices to prevent unauthorized access to personally identifiable information of responders or unauthorized use of social media.

(See Capability 6: Information Sharing)

E/T3: PPE consistent with the identified risks and associated job functions of public health response personnel. Equipment may include

- Coveralls
- Gloves
- Boots or shoes that are chemical-resistant with steel toe and shank

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- Outer, chemical-resistant (disposable) clothing
- Safety glasses or chemical splash goggles
- Hard hat
- Face shield
- Goggles
- National Institute of Occupational Safety and Health (NIOSH)-approved or FDA-approved filtering facepiece respirators
- FDA-approved surgical masks
- Gowns

Function 2: Identify and support risk-specific responder safety and health training

Function Definition: Support responder safety and health training that accounts for physical safety, mental/behavioral health, use of hierarchical controls, such as administrative controls, engineering controls, and PPE, and other responder safety and health topics based on identified risks and recommendations.

Tasks

Task 1: Determine responder safety and health training needs. Conduct a training needs assessment to determine the types and frequency of training(s) required to support responder safety and health, such as physical safety, mental/behavioral health, pre-deployment requirements, such as immunization needs, and hierarchical protection and control measures.

Task 2: Support safety and health training initiatives. Support provision of just-in-time, initial, and ongoing emergency response safety and health training in partnership with jurisdictional emergency management, other agencies, and partnering organizations.

Preparedness Resource Elements

P1: (Priority) Procedures in place to ensure the completion, verification, and documentation of responder safety and health training prior to and during an incident to ensure jurisdictional public health personnel and supporting surge capacity personnel are prepared to respond to emergencies and understand the jurisdictional Incident Command System.

Skills and Training Resource Elements

S/T1: (Priority) Responder safety and health training topics may include

- Safety awareness
- Self-care or buddy care
- Communications
- Incident Command System
- Site operations
- Hazard communication
- Decontamination
- Respiratory protection

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- PPE
- Hazardous waste operations
- Medical record management
- Responder tracking and use of registries
- Immunization needs
- Relevant information systems, such as immunization information systems and registries

S/T2: (Priority) Personnel qualified to conduct trainings for public health responders.

S/T3: (Priority) Personnel trained, as appropriate for their roles, in level A, B, or C OSHA PPE standards awareness and technical response trainings.

S/T4: (Priority) Personnel trained on safely donning and doffing various types of PPE and safe handling and disposal of infectious or contaminated waste (depending on role).

S/T5: (Priority) Personnel who are required to use N95 or other respirators as part of their job duties, including response roles, enrolled in a respiratory protection program that is established and maintained by their employer. This program would include medical clearance and fit testing for respirator wear.

Equipment and Technology Resource Elements

E/T1: PPE consistent with the identified jurisdictional risks and job functions for public health response personnel.

E/T2: Respirator fit testing kit with a certified fit for public health responders.

E/T3: Immunization information systems (IISs) that include demographic records for all responders prior to an event. Equipment and software to assess immunization status and document immunizations administered before, during, and after incident response.

Function 3: Monitor responder safety and health during and after incident response

Function Definition: Coordinate with the Incident Safety Officer or others to conduct and participate in monitoring or surveillance activities to identify potential adverse health effects on public health responders, communicate identified hazards and control measures, and provide medical support services, as necessary.

Tasks

Task 1: Conduct responder safety and health monitoring and surveillance. Ensure the appropriate level of safety monitoring and health surveillance for responders based on identified risks, jurisdictional responder roles, and subject matter expert recommendations.

Task 2: Document additional incident-specific safety and health risks. Identify potential responder safety and health risks based on responder monitoring and surveillance findings.

Task 3: Update incident safety plan. Update and revise the incident safety plan, as needed, based on responder monitoring and surveillance findings.

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Task 4: Conduct responder in-processing. Ensure appropriate badging and rostering during on-site incident responder in-processing.

Task 5: Conduct exposure assessment activities. Execute or provide guidance on exposure assessment activities to identify evidence and documentation of hazardous exposures.

Task 6: Provide mental/behavioral and medical support services. Coordinate with health care partners to facilitate access to and promote the availability of mental/behavioral and medical support for responders, as necessary.

Task 7: Track responder demobilization and out-processing. Conduct post-deployment responder out-processing and track responder physical and mental/behavioral health status upon demobilization.

Preparedness Resource Elements

P1: (Priority) Documentation of incident-specific responder safety and health risks, threats, and necessary precautions identified by the jurisdictional public health agency in collaboration with partner agencies.

P2: (Priority) Public health responder on-site rostering and badging to facilitate visual identification of responders and ensure access to appropriate resources and facilities based on responder roles. Rostering and badging procedures should address

- Computer or other technological resource access
- Collection of demographic information
- Collection of personal information, including emergency contact information
- Collection of pre-incident health assessment information
- Incident and organization badging
- Job assignment
- PPE dispensing
- Physical location access
- Site-specific training
- Verification of valid, current professional licenses and trade certifications
- Visual identification

P3: Procedures in place to support volunteer needs during the response. Volunteer needs may include

- Housing
- Safe food and potable water
- Medical countermeasures, including vaccinations
- First aid and emergency medical care
- Mental/behavioral health services

(See Capability 1: Community Preparedness and Capability 2: Community Recovery)

P4: (Priority) Procedures in place for monitoring, exposure assessment, and sampling activities to assess levels of environmental exposure and effects on individual responders and procedures in place for surveillance activities to assess actions, practices, and trends that contribute to incident-related physical and behavioral illnesses and injuries.

(See Capability 13: Public Health Surveillance and Epidemiological Investigation)

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P5: (Priority) Incident safety plans, such as site safety and control plan and medical plan (ICS 206 and 208) updated to reflect monitoring, exposure assessment, sampling, and surveillance findings.

(See Capability 3: Emergency Operations Coordination and Capability 9: Medical Materiel Management and Distribution)

P6: (Priority) Communication strategy for disseminating detailed results of responder safety and health monitoring and surveillance to responders, the public, and the media. CDC recommends that communications be cleared, as appropriate, and address

- Known pre-incident risks
- Risks encountered during the response to the incident
- Considerations to manage identified risks and update incident safety plan
- Morbidity and mortality related to the incident

(See Capability 4: Emergency Public Information and Warning)

P7: (Priority) Procedures in place to ensure responders are properly demobilized after a response. Demobilization procedures may include

- Formal check-out or out-processing activities to document responders' health status including physical and mental/behavioral health before they leave the worksite
- Documentation of contact information for each responder
- Procedures developed or modified for the incident to identify responders with incident-related delayed or long-term adverse health effects. Indicators for delayed or long-term adverse health effects may include
  - Hazardous work exposures
  - Hazardous work activities
  - Injuries and illness incurred during deployment
  - Concerns, such as political and public, expressed by others
- Collection of after-action information during out-processing to identify lessons learned and support corrective action planning

(See Capability 3: Emergency Operations Coordination)

P8: Procedures in place to provide long-term support for responders and conduct periodic assessments of responder safety and health measures. Procedures may include

- Exposure assessments
- Environmental sampling
- Long-term mental health considerations
- Medical examination results
- Medical monitoring and surveillance
- Out-processing interview and data collection
- Pre-deployment baseline assessments and review of activity logs

(See Capability 2: Community Recovery and Capability 3: Emergency Operations Coordination)

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Equipment and Technology Resource Elements

E/T1: Registry or database created in coordination with emergency management entities to document responders exposed to hazards or injured during an incident.

E/T2: Equipment and software to collect, analyze, and report responder safety and health data during and after incident response.

(See Capability 6: Information Sharing)

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Capability 15: Volunteer Management

Definition: Volunteer management is the ability to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support the jurisdictional public health agency's preparedness, response, and recovery activities during pre-deployment, deployment, and post deployment.

Functions: This capability consists of the ability to perform the functions listed below.

- **Function 1:** Recruit, coordinate, and train volunteers
- **Function 2:** Notify, organize, assemble, and deploy volunteers
- **Function 3:** Conduct or support volunteer safety and health monitoring and surveillance
- **Function 4:** Demobilize volunteers

Summary of Changes: The updates align content with new national standards, updated science, and current public health priorities and strategies. Listed below are specific changes made to this capability.

- Addresses the need to monitor volunteer safety, risks, and actions during and after an incident
- Strengthens and clarifies volunteer eligibility considerations, such as medical, physical, and emotional health, during the volunteer selection process
- Promotes use of Emergency Responder Health Monitoring and Surveillance™ (ERHMS™)

For the purposes of Capability 15, partners and stakeholders may include the following:

- academic institutions
- emergency management agencies
- faith-based organizations
- government agencies
- health care coalitions
- health care organizations
- professional associations
- volunteer programs and organizations[13]

[14] For example, the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), the Medical Reserve Corps (MRC), the National Voluntary Organizations Active in Disaster (NVOAD), the American Red Cross, Radiation Response Volunteer Corps (RRVC), community emergency response teams (CERTs), and other jurisdictional nongovernmental or community service organizations.

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Function 1: Recruit, coordinate, and train volunteers

Function Definition: Identify, recruit, register, verify, and train volunteers to support the jurisdictional public health agency incident response.

Tasks

Task 1: Identify needs for volunteers and other supporting resources. Identify the types and numbers of volunteers and other supporting resources needed to address potential public health responses based on jurisdictional risk assessments.

Task 2: Recruit volunteers. Support the pre-incident recruitment of volunteers needed in a potential jurisdictional public health response by coordinating with existing volunteer programs and partner organizations.

Task 3: Verify volunteer credentials. Ensure pre-incident screening and verification of volunteer credentials through jurisdictional ESAR-VHP, MRC, or other volunteer programs.

Task 4: Support volunteer emergency response training. Support provision of just-in-time, initial, and ongoing emergency response training, including access and functional needs training, for registered volunteers in partnership with jurisdictional MRC unit(s) and other partner groups.

Preparedness Resource Elements

P1: (Priority) Volunteers and other resources identified as necessary to respond to public health incidents or events based on jurisdictional risks. Considerations for volunteers may include

- Functional roles, assignments, and corresponding competencies
- Description of necessary skills, knowledge, such as language proficiency and expertise on access and functional needs, or credentials for each volunteer task or role
- Timeline for mobilizing and assembling volunteers
- Plan and triggers for when to activate volunteers including deployments
- Jurisdictional authorities that govern issues of volunteer liability and scope of practice

(See Capability 1: Community Preparedness and Capability 14: Responder Safety and Health)

P2: (Priority) Written agreements, such as contracts or memoranda of understanding (MOUs), established with jurisdictional or regional volunteer sources, as needed, to address potential public health responses. Recommended partnership agreements may include

- Partner organizations' promotion of public health volunteer opportunities
- Registration requirements for ESAR-VHP, MRC, or other pre-identified partner groups, such as the American Red Cross or CERTs
- Liability protection for volunteers
- Recognition of qualifications and certifications
- Efforts to continually engage volunteers through routine community health promotion activities
- Identification and administration of appropriate trainings for volunteers
- Documentation of the volunteer affiliations, such as employers and volunteer organizations at federal, state, local, tribal, and territorial levels to assist in minimizing "double counting" of prospective volunteers

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P3: Verification of professional volunteer diplomas, licenses, certifications, credentials, and registrations in accordance with federal and state laws using the state's ESAR-VHP or other programs, as appropriate.

P4: Deployment eligibility for pre-identified volunteer responders based on medical, physical, and mental/behavioral health screenings and background checks. Eligibility criteria may include

- Medical health, such as immunization status, medications, and pre-existing conditions
- Physical fitness
- Mental/behavioral health
- Criminal records, such as sexual offender registry

(See Capability 14: Responder Safety and Health)

Skills and Training Resource Elements

S/T1: Documentation of completed training(s), as required by the jurisdiction, to prepare volunteers for their assigned responsibilities. Recommended trainings may include those addressing

- Cardiopulmonary resuscitation (CPR)
- Basic first aid skills
- Medical countermeasure dispensing roles
- Incident Command System training
- Basic triage skills, psychological first aid, and self-care
- Basic and advanced disaster life support (American Medical Association's [AMA] National Disaster Life Support Program)
- Cultural competency
- Access and functional needs during a disaster response
- HazMat awareness
- MRC TRAIN (as applicable to the jurisdiction)
- Privacy and confidentiality of information collected during emergency response
- Other skills and courses identified by the jurisdiction for specific roles

S/T2: Personnel trained in volunteer management. Recommended training may include FEMA IS244.B: Developing and Managing Volunteers.

S/T3: Prospective volunteers trained in jurisdictional incident management or National Incident Management System (NIMS) trainings, which may include

- Introduction to Incident Command System (IS-100)
- NIMS- An Introduction (IS-700.a)
- Incident Command System for Single Resources and Initial Action Incidents (IS-200.b)
- Incident Command System (IS-300) and Advanced ICS Command and General Staff (IS-400) for volunteer leaders that will hold key leadership positions
- MRC Volunteer Orientation

Equipment and Technology Resource Elements

E/T1: Access to a system or registry for volunteer managers to track the number of registered volunteers by profession and skill level, the number of hours of volunteer services performed, and previous volunteer activities in incident responses. The system or registry should be capable of reporting data to the Volunteer Reception Center (VRC).

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E/T2: Information technology (IT) security measures that prevent unauthorized access to any personally identifiable information (PII) of volunteers.

Function 2: Notify, organize, assemble, and deploy volunteers

Function Definition: Notify, organize, assemble, and deploy volunteers participating in the jurisdictional public health agency response efforts based on identified assignments and incident characteristics.

Tasks

Task 1: Identify incident-specific volunteer needs. Identify the number of volunteers, skills, and resources needed to support an incident based on existing volunteer registration lists.

Task 2: Identify volunteers. Contact volunteer organizations to support the identification of volunteers based on incident-specific needs.

Task 3: Notify registered volunteers of incident-specific assignment details. Notify pre-incident registered volunteers who are able and willing to respond and share assignment details using multiple modes of communication.

Task 4: Request additional volunteers as needed. Notify partner organizations of any additional volunteer needs and request additional volunteers.

Task 5: Manage or support spontaneous volunteers. Manage spontaneous volunteers by incorporating them into the incident response or triaging them to other potential volunteer agencies, as applicable.

Preparedness Resource Elements

P1: Procedures in place to coordinate with partners, inter- and intrajurisdictional agencies, and other relevant organizations, contact registered volunteers, identify volunteers willing and able to respond, identify supporting resources needed for volunteers, and share incident-specific assignment details. Recommended procedures may include

- Processes to describe how the jurisdictional public health agency requests volunteers
- Processes to determine the best use of available volunteers based on mission and capabilities
- Processes for the jurisdictional public health agency to request federal resources, such as personal protective equipment (PPE), response-specific vaccinations, and response teams, that include a clear statement of need, list of requested asset(s), and role of the requested asset(s), if applicable
- Plans for communications between state and local health departments about volunteer needs and assignments during an incident
- Plans to provide volunteer pre-deployment briefings that describe incident conditions and assignment details. Briefing topics should include
  - Incident or event details
  - Volunteer roles and responsibilities
  - Health safety risks
  - PPE
  - Local weather
  - Liability protection

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  - Living and work conditions
  - Nature of the work site
  - Personal security risks
  - Required immunizations or prophylaxis
  - Required identification for rostering and badging volunteers
- Procedures to assign volunteers to other response agencies

(See Capability 3: Emergency Operations Coordination, Capability 4: Emergency Public Information and Warning, Capability 6: Information Sharing, and Capability 14: Responder Safety and Health)

P2: Procedures in place to identify public health agency personnel and their roles and responsibilities in volunteer management.

P3: Procedures in place to coordinate with agencies and organizations involved in the identification of volunteers.

P4: (Priority) Procedures in place to support additional and spontaneous volunteers, meaning volunteers not pre-identified. Recommended procedures may include

- Informing volunteers how to report to appropriate incident management leads, such as volunteer coordinators or off-site incident command
- Ensuring all volunteers follow standardized, in-processing requirements
- Identifying duties spontaneous volunteers can perform
- Verifying credentials of spontaneous volunteers
- Managing spontaneous volunteers who are not assigned to the appropriate job functions or tasks based on their skills and the needs of the response
- Registering spontaneous volunteers for future emergency responses
- Referring spontaneous volunteers who are not aligned with an identified partner organization to other organizations, such as nonprofits or MRC

(See Capability 4: Emergency Public Information and Warning and Capability 14: Responder Safety and Health)

P5: Procedures in place to support volunteer needs during the response. Volunteer needs may include

- Housing
- Safe food and potable water
- Medical countermeasures or vaccination
- First aid and emergency medical care
- Mental/behavioral health services

(See Capability 1: Community Preparedness and Capability 2: Community Recovery)

Equipment and Technology Resource Elements

E/T1: Communication equipment for public health agency personnel to contact volunteer organizations. Communication equipment may include

- Phones
- Computers
- HAM or hand radios

(See Capability 6: Information Sharing and Capability 10: Medical Surge)

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E/T2: Volunteer registries and rosters that are maintained with the appropriate IT security measures to safeguard PII.

(See Capability 6: Information Sharing)

E/T3: (Priority) PPE consistent with incident risks and associated job functions of volunteers.

Function 3: Conduct or support volunteer safety and health monitoring and surveillance

Function Definition: Conduct or support monitoring and surveillance activities to identify potential volunteer safety and health needs.

Tasks

Task 1: Communicate incident-specific safety and health risks to volunteers. Identify potential volunteer safety and health risks based on incident characteristics and communicate identified risks and recommended precautions to volunteers.

Task 2: Conduct volunteer safety and health monitoring and surveillance. Ensure volunteer safety and health monitoring and surveillance are conducted according to volunteer role risk profile(s).

Preparedness Resource Elements

P1: (Priority) Documentation of incident-specific volunteer safety and health risks, threats, and precautions identified by the jurisdictional public health agency and lead partners, such as occupational health and safety, environmental health, and radiation control programs.

P2: (Priority) Procedures in place to conduct standardized assessments of the identified safety and health risks and threats as well as the effectiveness of precautions and mitigation measures used, such as training effectiveness and PPE compliance.

(See Capability 14: Responder Safety and Health)

P3: (Priority) Surveillance activities to assess trends in actions and practices that contribute to incident-related physical illness or injury and mental/behavioral trauma.

(See Capability 13: Public Health Surveillance and Epidemiological Investigation)

P4: Procedures in place to communicate the results of volunteer safety and health monitoring and surveillance to responders, the public, and the media (as applicable). Communicated risks should include both known pre-incident risks and risks encountered during the incident response.

Equipment and Technology Resource Elements

E/T1: Surveillance and monitoring systems or databases to track volunteer health and safety.

(See Capability 13: Public Health Surveillance and Epidemiological Investigation and Capability 14: Responder Safety and Health)

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Function 4: Demobilize volunteers

Function Definition: Support the release of volunteers based on evolving incident needs or incident action plans and coordinate with partner agencies and organizations to support the provision of any medical and mental/behavioral health support for volunteers.

Tasks

Task 1: Manage volunteer demobilization and out-processing. Conduct post-deployment volunteer out-processing and track volunteer physical and behavioral health status during demobilization.

Task 2: Provide post-incident support to volunteers. Determine need for long-term medical and mental/behavioral health support for volunteers based on information collected from volunteers during the response and at demobilization.

Task 3: Conduct after-action reviews and develop after-action reports and improvement plans. Conduct after-action reviews and develop after-action reports (AARs) and improvement plans (IPs) that identify corrective actions specific to volunteer management to improve future operations.

Preparedness Resource Elements

P1: (Priority) Procedures in place to ensure proper demobilization of volunteers after a response, which may include

- Procedures to collect contact information from each volunteer responder
- Formal check-out or out-processing activities to document volunteer health status including physical and mental/behavioral, as applicable, before volunteers leave the worksite
- Procedures to identify volunteer responders with incident-related delayed or long-term adverse health effects. Identification criteria may include
  - Hazardous material exposures
  - Hazardous work activities
  - Adequacy of control measures
  - Injuries and illness incurred during deployment
  - Other risks identified by jurisdictional stakeholders
- After-action processes to identify corrective actions and lessons learned

(See Capability 2: Community Recovery, Capability 3: Emergency Operations Coordination, and Capability 14: Responder Safety and Health)

P2: Procedures in place to provide long-term support for volunteers and conduct periodic assessments of volunteer responder safety and health measures. Procedures may include

- Exposure assessments
- Environmental sampling
- Long-term mental health considerations
- Medical examination results
- Medical monitoring and surveillance

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- Out-processing interview and data collection
- Pre-deployment baseline assessments and review of activity logs

(See Capability 3: Emergency Operations Coordination and Capability 14: Responder Safety and Health)

Equipment and Technology Resource Elements

E/T1: Registry or database created in coordination with emergency management entities and used to document volunteer responders exposed to hazards or injured during an incident or response.

E/T2: Equipment and software to collect, analyze, and report volunteer responder safety and health data during and after an incident or response.

(See Capability 6: Information Sharing)

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Glossary of Terms

Access and functional needs: Refers to persons who may have additional needs before, during and after an incident in functional areas, including but not limited to: maintaining health, independence, communication, transportation, support, services, self-determination, and medical care. Individuals in need of additional response assistance may include those who have disabilities; live in institutionalized settings; are older adults; are children; are from diverse cultures; have limited English proficiency or are non-English speaking; or are transportation disadvantaged (U.S. Federal Emergency Management Agency definition).

Acquire: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to requesting medical materiel (inclusive of medical countermeasures) from the stockpile source or otherwise obtaining it from commercial sources or through mutual aid agreements.

Administer: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to the act of a clinician or other trained provider giving a medical countermeasure to an individual according to protocols established for that incident, ensuring

- The right individual
- The right medical countermeasure
- The right timing, including the correct age and interval, as well as before the product expiration time and date
- The right dosage
- The right route, including the correct needle gauge, length, and technique
- The right site
- The right documentation

Protocols for the administration of medical countermeasures may consist of routine standard of practice guidance, such as how to give an injection, or may deviate from standard practice if involving emergency use authorizations, investigational new drug protocols, or the federal Shelf Life Extension Program.

Some medical countermeasures must be administered by a clinician or other trained personnel, such as vaccines administered by injection. This task is different from dispensing medical countermeasures when an individual can independently take a pill or use a device without further clinical supervision.

Adverse events reporting: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, adverse events reporting involves multidirectional information sharing about possible side effects or health problems that may occur after medical countermeasures are dispensed or administered. The process not only includes solicitation and collection of adverse event information by jurisdictional authorities from health care providers and persons who receive medical countermeasures, but also includes information sharing with the community, especially health care providers, about possible adverse events. Reporting adverse events may occur on a national, jurisdictional, or even dispensing site level. Jurisdictions should use national reporting systems, such as the Vaccine Adverse Event Reporting System (VAERS] or the Food and Drug Administration's (FDA) MedWatch. Jurisdictions may need to develop other jurisdiction-specific mechanisms for identifying and managing adverse events.

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Adverse events reporting systems: Systems that collect, analyze, and disseminate information about adverse events. Systems can be national, such as VAERS or FDA MedWatch, or jurisdictional, such as identifying adverse advents at the dispensing site level.

After-action report (AAR): Report that summarizes and analyzes performance in both exercises and real incidents or events. The reports for exercises also may evaluate achievement of the selected exercise objectives and demonstration of the overall capabilities being exercised.

Alert: Time-sensitive tactical communication sent to parties potentially impacted by an incident to increase preparedness and response. Alerts can convey 1) urgent information for immediate action, 2) interim information with actions that may be required in the near future, or 3) information that requires minimal or no action by responders. CDC's Health Alert Network is a primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, local, tribal, and territorial public health practitioners; clinicians; and public health laboratories.

Antemortem data: Information about a missing or deceased person used for identification. This information includes demographic and physical descriptions, medical and dental records, and information regarding the person's last known whereabouts. Antemortem information is gathered and compared to postmortem information when confirming a victim's identification.

Assessment of Chemical Exposures (ACE) Program Toolkit: Contains surveys, consent forms, training materials, and Epi Info 7 databases that easily can be customized for use in an assessment after a chemical incident. The ACE team also provides training in conducting rapid epidemiologic assessments after chemical releases.

At-risk individuals: At-risk individuals are people with access and functional needs that may interfere with their ability to access or receive medical care before, during, or after a disaster or emergency. Irrespective of specific diagnosis, status, or label, the term "access and functional needs" is a broad set of common and cross-cutting access and function-based needs. The 2013 Pandemic and All-Hazards Preparedness Reauthorization Act defines at-risk individuals as children, older adults, pregnant women, and individuals who may need additional response assistance. Examples of these populations may include but are not limited to individuals with disabilities, individuals who live in institutional settings, individuals from diverse cultures, individuals who have limited English proficiency or are non-English speaking, individuals who are transportation disadvantaged, individuals experiencing homelessness, individuals who have chronic medical disorders, and individuals who have pharmacological dependency (U.S. Department of Health and Human Services definition). However, jurisdictions should use their own discretion in determining which populations are at risk to be disproportionately impacted by a particular incident or event.

Biosafety level-3: Biosafety levels are designated in ascending order by degree of protection provided to personnel, the environment, and the community. Standard microbiological practices are common to all laboratories. Special microbiological practices enhance worker safety and environmental protection and address the risk of handling agents requiring increasing levels of containment.

Biosafety level 3 is applicable to clinical, diagnostic, teaching, research, or production facilities where work is performed with indigenous or exotic agents that may cause serious or potentially lethal disease through the inhalation route of exposure. Laboratory personnel must receive specific training in handling pathogenic and potentially lethal agents and must be supervised by scientists competent in handling infectious agents and associated procedures.

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Broselow tapes: Color-coded strips of paper inscribed at length-based intervals with information on the use of fluids, pressors, anticonvulsants, and resuscitation equipment. They are used to provide a quick estimate of the weight of pediatric patients and provide a rapid means of determining the dosages of medications and the size of the equipment that should be used in pediatric resuscitations.

Chain of custody requirements: Tracking of possession of and responsibility for medical materiel during the distribution process.

Closed point of dispensing (closed POD or CPOD): For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to a dispensing site that serves a defined population and is not open to the public.

CMIST framework: The Communication; Maintaining Health; Independence; Support, Safety and Self-determination; Transportation (CMIST) framework defines cross-cutting categories of the access and functional needs of at-risk individuals. The framework addresses a broad set of common access and functional needs that are not tied to specific diagnoses, status, or labels, such as pregnant women, children, or elderly. Ultimately, individuals with access and functional needs must be addressed in all federal, territorial, tribal, state, and local emergency preparedness and response plans.

Community Assessment for Public Health Emergency Response (CASPER): An epidemiologic technique designed to provide quickly and at low-cost household-based information about a community. The CASPER toolkit was developed to assist personnel from any local, state, regional, or federal office in conducting a rapid needs assessment to determine the health status, basic needs, or knowledge, attitudes, and practices of a community in a quick and low-cost manner. Gathering health and basic needs information using valid statistical methods allows public health and emergency managers to make informed decisions. The CASPER tool kit provides guidelines on data collection tool development, methodology, sample selection, training, data collection, analysis, and report writing.

Community emergency response team (CERT): A program that educates volunteers about disaster preparedness for the hazards that may impact their area and trains them in basic disaster response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. CERT offers a consistent, nationwide approach to volunteer training and organization on which professional responders can rely during disaster situations, which allows them to focus on more complex tasks.

Community mitigation strategies: For the purposes of Capability 11: Nonpharmaceutical Interventions, community mitigation strategies refer to

- Isolation
- Quarantine
- Restrictions on movement and travel advisories and warnings
- Social distancing
- External decontamination
- Hygiene
- Precautionary protective behaviors

Community outreach information network (COIN): A grassroots network of people and trusted leaders who can help with emergency response planning and delivering information to at-risk populations in emergencies.

Community resilience: Community resilience can be defined as the capacity to

- Absorb stress or destructive forces through resistance or adaptation
- Manage or maintain certain basic functions and structures during disastrous events
- Recover or "bounce back" after an event

A focus on resilience means putting more emphasis on what communities can do for themselves and how to

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strengthen their capacities, rather than concentrating on their vulnerability to disaster or their needs in an emergency.

Corrective action plans: Improvements and corrective actions that are implemented based on lessons learned from actual incidents or from training and exercises.

Critical infrastructure: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to assets, systems, and networks, whether physical or virtual, so vital to the United States that the incapacitation or destruction of such assets, systems, or networks would have a debilitating impact on security, national economic security, national public health or safety, or any combination of those matters. Critical infrastructure depends on the incident and jurisdictional characteristics.

Critical workforce: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to personnel required to maintain critical infrastructure. Specific personnel considered to be critical workforce depends on the incident and jurisdictional characteristics.

Demobilize: Release and return of resources that are no longer required for the support of an incident or event.

Deployment: The movement of assets, including personnel, to a specific area.

Dispensing: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, dispensing means to prepare and give out a medication to targeted individuals. Some medical countermeasures, like pills or devices, can be provided to an individual for self-administration. This task is different from medical countermeasure administration, for which clinicians or other trained personnel are needed, such as to administer vaccines by injection.

Dispensing/administration sites: Locations where targeted populations can receive medical countermeasures, whether through the dispensing of pills or the administration of medicines and vaccines. Examples of dispensing/administration sites include open PODs, CPODs, vaccination clinics, pharmacies, and other sites in the community that meet requirements for dispensing/administration sites.

Disposition of human remains: For the purposes of Capability 5: Fatality Management, disposition refers to individual burial, state-sponsored individual burial, entombment, mass burial, voluntary cremation, and involuntary cremation.

Distribution assets: Resources needed to transport medical materiel during an incident or event response, such as personnel, equipment, supplies, and technology.

Distribution site: Locations that receive medical countermeasures for eventual transport to dispensing/administration sites. These locations include receipt, stage, store (RSS) sites, regional distribution sites, local distribution sites, hospitals, or other sites. Distribution sites must be validated as appropriate to receive, store, and distribute medical countermeasure assets. This may include assessments of the physical facility and surrounding area, security considerations, staffing information, and environmental controls including cold chain management.

Durable medical equipment: Equipment that can withstand repeated use, provides therapeutic benefits to a patient in need because of certain medical conditions or illnesses, and can be recovered after an emergency, such as ventilators.

Emergency Management Assistance Compact (EMAC): An all-hazards, all-disciplines, mutual-aid compact that serves as the cornerstone of the nation's mutual aid system. EMAC is the first national disaster-relief compact since the Civil Defense and Disaster Compact of 1950 to be ratified by the U.S. Congress. EMAC offers assistance during governor-declared states of emergency or disaster through a responsive, straightforward

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system that allows states to send personnel, equipment, and commodities to assist with response and recovery efforts in other states. Through EMAC, states also can transfer services, such as shipping newborn blood from a disaster-impacted laboratory to a laboratory in another state, and conduct virtual missions, such as GIS mapping. Since ratification and signing into law in 1996 (Public Law 104-321), 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands have enacted legislation to become EMAC members.

Emergency Prescription Assistance Program (EPAP): Provides an efficient mechanism for more than 70,000 enrolled retail pharmacies nationwide to process claims for certain kinds of prescription drugs, specific medical supplies, vaccines, and some forms of durable medical equipment for eligible individuals in a federally identified disaster area.

Emergency Support Functions (ESFs): Grouping of governmental and certain private sector capabilities into an organizational structure to provide support, resources, program implementation, and services that are most likely needed to save lives, protect property and the environment, restore essential services and critical infrastructure, and help victims and communities return to normal following domestic incidents. The 15 ESFs are annexes to the United States National Response Framework (NRF). While the primary ESF supported by public health agencies is ESF #8—Public Health and Medical Services, public health agencies also may support other ESFs in coordination with jurisdictional partners and stakeholders.

Essential elements of information (EEI): Discrete types of reportable public health or health care-related, incident-specific knowledge communicated or received concerning a particular fact or circumstance, preferably reported in a standardized manner or format, which assists in generating situational awareness for decision-making purposes. EEI are often coordinated and agreed upon before an incident, and communicated to local partners as part of information collection request templates and emergency response playbooks.

Essential Public Health Services: Public health activities that all communities should undertake. The Core Public Health Functions Steering Committee developed the framework for the Essential Services in 1994. The committee included representatives from U.S. Public Health Service agencies and other major public health organizations. The 10 Essential Public Health Services are

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

Event: A planned, non-emergency activity, such as a concert, convention, parade, or sporting event.

Gridding: The process of establishing the exact location of any item based on the slope and distance from an established point.

Health alert network: A primary method of sharing cleared information about urgent public health incidents with public information officers; federal, state, local, tribal, and territorial health practitioners; clinicians; and public health laboratories.

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Hierarchy of controls: A framework used as a means of determining how to implement feasible and effective control solutions.

Homeland Security Exercise and Evaluation Program (HSEEP): A capabilities- and performance-based exercise program that provides a standardized policy, methodology, and language for designing, developing, conducting, and evaluating all exercises.

Homeland Security Information Network (HSIN): The trusted network for Department of Homeland Security (DHS) mission operations to share sensitive, but unclassified information. Federal, state, local, territorial, tribal, international, and private sector homeland security partners use HSIN to manage operations, analyze data, send alerts and notices, and, in general, share the information they need to do their jobs.

Human impact: Refers to indicators, such as number of fatalities resulting from a particular hazard, injuries requiring emergency medical services transport, outpatient injuries, and hospital emergency department visits due to injury or illness.

Human services: For the purposes of the capabilities document, the definition of human services draws from ESF #6—Mass Care, Emergency Assistance, Temporary Housing, and Human Services Annex. Human services refers to the implementation by public health agencies and their partners and stakeholders of disaster assistance programs that help survivors address unmet disaster-caused needs or non-housing losses through loans and grants, supplemental nutrition assistance, crisis counseling, disaster case management, disaster unemployment, disaster legal services, and other state and federal human services programs and benefits to survivors. ESF #6—Mass Care, Emergency Assistance, Temporary Housing, and Human Services Annex also coordinates closely with the Health and Social Services Recovery Support Function to ensure continuous support for social services needs in the impacted communities.

Hygiene: Behaviors that can improve cleanliness and lead to good health, such as frequent hand washing, face washing, and bathing with soap and water.

Incident: An occurrence, either human-caused or naturally occurring, that requires action to prevent or minimize loss of life or damage to property or natural resources. In the context of the capability standards, the term "incident" is used to describe any scenario, threat, disaster, or other public health emergency.

Incident Command System (ICS): ICS is a management system designed as part of the Federal Emergency Management Agency's (FEMA's) National Incident Management System (NIMS) to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. ICS is normally structured to facilitate activities in five major functional areas: command, operations, planning, logistics, intelligence and investigations, finance, and administration. It is a fundamental form of management, with the purpose of enabling incident managers to identify the key concerns associated with the incident—often under urgent conditions—without sacrificing attention to any component of the command system.

Intermediary/intermediate distribution sites: Any facility between the initial receiving site and the final delivery location where medical countermeasures are dispensed to the public. These sites could include regional distribution sites (RDSs), local distribution sites (LDSs), or any other facility noted in the jurisdiction's planning documents.

Inventory Management and Tracking System (IMATS): A CDC information technology (IT) platform developed with input from state and local jurisdictions that allows public health agencies to track medical countermeasure inventory down to the local level during an event, monitor reorder thresholds, and support warehouse operations,

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including receiving, staging, and storing inventory. IMATS also supports data exchange and allows state public health agencies to collect inventory totals from local jurisdictions.

Isolation: The separation of persons who have a specific infectious illness from those who are healthy and the restriction of their movement to stop the spread of that illness. Isolation allows for the focused delivery of specialized health care to people who are ill and protects healthy people from getting sick.

Joint Information Center (JIC): A facility established to coordinate all incident-related public information activities. It is the central point of contact for all news media at the scene of the incident. Public information officials from all participating agencies should collocate at the JIC.

Joint Information System (JIS): Integrates incident information and public affairs into a cohesive organization designed to provide consistent, coordinated, timely information during crisis or incident operations. The mission of the JIS is to provide a structure and system for developing and delivering coordinated interagency messages; developing, recommending, and executing public information plans and strategies on behalf of the incident commander; advising the incident commander concerning public affairs issues that could affect a response effort; and controlling rumors and inaccurate information that could undermine public confidence in the emergency response effort.

Jurisdictions: Planning areas, such as cities, counties, states, regions, territories, and freely associated states.

Laboratory Information Management System (LIMS): A software program that enables laboratories to fulfill data exchange needs for the Laboratory Response Network using their own systems.

Laboratory Response Network (LRN): A coordinated network of public health and other laboratories for which CDC provides standard assays and protocols for testing biological and chemical terrorism agents. The categories of laboratories include LRN-C focusing on chemical threats and LRN-B focusing on biological threats. Although referenced in the capabilities document, LRN-R for radiological threats has not been established.

The LRN is charged with maintaining an integrated network of state and local public health, federal, military, and international laboratories that can respond to bioterrorism, chemical terrorism, and other public health emergencies. The LRN also links state and local public health, veterinary, agriculture, military, and water- and food-testing laboratories.

Local Emergency Planning Committee (LEPC): The Emergency Planning and Community Right-to-Know Act (EPCRA) establishes the LEPC as a local forum for discussions and a focus for action in matters pertaining to hazardous materials planning. LEPCs also help to provide local governments and the public with information about possible chemical hazards in their communities.

Medical countermeasures: Medicines and medical supplies that may be used to prevent, mitigate, or treat the adverse health effects of an intentional, accidental, or naturally occurring public health emergency. In the capabilities document

- **Capability 8:** Medical Countermeasure Dispensing and Administration focuses on the pharmaceutical medical countermeasures, such as biologic products, such as vaccines, blood products, or antibodies) and drugs for example, antimicrobial or antiviral drugs.
- **Capability 9:** Medical Materiel Distribution and Management discusses medical materiel, of which medical countermeasure is a subset. Medical materiel also covers personal protective equipment, ventilators, syringes, and other items
- **Capability 12:** Public Health Laboratory Testing covers diagnostics material to identify threat agents

Other items, such as window screens and insect repellents, may be considered as medical countermeasures, depending on the needs of the public health emergency.

Medical materiel: For the purposes of Capability 9: Medical Materiel Distribution and Management, any equipment, apparatus, or supplies that are needed to prevent, mitigate, or treat the adverse events of a public health incident. Medical materiel may include medicines, vaccines, durable medical equipment, ventilators, personnel protective equipment for responders, ancillary medical supplies, and laboratory supplies and assays.

Medical Reserve Corps (MRC): A national network of local groups of volunteers engaging local communities to strengthen public health, reduce vulnerability, build resilience, and improve preparedness, response, and recovery capabilities.

Medicolegal: Relating to both medicine and law.

MedWatch: FDA's safety information and adverse event reporting program. MedWatch is used for reporting an adverse event or sentinel event. Founded in 1993, this system of voluntary reporting allows such information to be shared with the medical community or the general public. The system includes publicly available databases and online analysis tools for professionals. MedWatch also disseminates medical product safety alerts, such as recalls and other clinical safety communications, via its website, e-mail list, Twitter, and RSS feed.

Memorandum of understanding (MOU): A document that describes a broad concept of mutual understanding, goals, and plans shared by the parties.

Mental/behavioral health: An overarching term to encompass behavioral, psychosocial, substance abuse, and psychological health.

Mission scoping assessment: A summary of findings and issues identified by the six federal recovery support functions supporting the National Disaster Recovery Framework mission.

National Voluntary Organizations Active in Disaster (NVOAD): An association of organizations that mitigate and alleviate the impact of disasters; provides a forum promoting cooperation, communication, coordination and collaboration; and fosters more effective delivery of services to communities affected by disaster.

National Disaster Medical System (NDMS): A cooperative asset-sharing program that augments local medical care when an emergency exceeds the scope of a community's hospital and health care resources. The emergency resources, which include approximately 8,000 medical and support personnel, come from federal, state and local governments, the private sector, and civilian volunteers.

National Emergency Medical Services Information System (NEMSIS): A national database that is used to store emergency medical services (EMS) data from U.S. states and territories. NEMSIS is a universal standard for how patient care information resulting from an emergency 911 call for assistance is collected. NEMSIS is a collaborative system to improve patient care through the standardization, aggregation, and utilization of point-of-care EMS data at local, state, and national levels.

National Incident Management System (NIMS): A comprehensive, national approach to incident management developed by FEMA that is applicable at all jurisdictional levels and across functional disciplines. It is intended to

1. Be applicable across a full spectrum of potential incidents, hazards, and impacts, regardless of size, location or complexity
2. Improve coordination and cooperation between public and private entities in a variety of incident management activities
3. Provide a common standard for overall incident management

NIMS provides a consistent nationwide framework and approach to enable government at all levels (federal, state, local,

tribal, and territorial), the private sector, and nongovernmental organizations (NGOs) to work together to prepare for, prevent, respond to, recover from, and mitigate the effects of incidents regardless of the incident's cause, size, location, or complexity. Consistent application of NIMS lays the groundwork for efficient and effective responses, from a single agency fire response to a multiagency, multijurisdictional natural disaster or terrorism response.

National Preparedness Goal: Defines what is meant for the whole community to be prepared for all types of disasters and emergencies. It outlines core capabilities required across the whole community to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk. These risks include events, such as natural disasters, disease pandemics, chemical spills and other human-caused hazards, terrorist attacks, and cyberattacks.

National Preparedness System: Outlines an organized process for everyone in the whole community to move forward with their preparedness activities and achieve the National Preparedness Goal. The National Preparedness System has six parts:

1. **Identifying and Assessing Risk**—involves collecting historical and recent data on existing, potential, and perceived threats and hazards. The results of these risk assessments form the basis for the remaining steps
2. **Estimating Capability Requirements**—includes determining the specific capabilities and activities to best address those risks. Some capabilities may already exist and some may need to be built or improved. FEMA provides a list of core capabilities related to prevention, protection, mitigation, response, and recovery, the five mission areas of preparedness
3. **Building and Sustaining Capabilities**—involves figuring out the best way to use limited resources to build capabilities. Risk assessments can be used to prioritize resources to address the highest probability or highest consequence threats
4. **Planning to Deliver Capabilities**—refers to coordinating plans with other organizations, which includes all parts of the whole community: individuals, businesses, nonprofits, community and faith-based groups, and all levels of government
5. **Validating Capabilities**—participating in exercises, simulations, real-incident events, or other activities helps to identify gaps in plans and capabilities. It also helps identify progress toward meeting preparedness goals
6. **Reviewing and Updating**—regularly reviewing and updating all capabilities, resources, and plans is important

Network of distribution sites: The jurisdiction-specific list of all sites that are used for the management and transportation of medical materiel. These include RSS sites, RDSs, LDSs, hospitals, or other sites. Distribution sites must be validated as appropriate to receive, store, and distribute medical countermeasure assets. This may include assessments of the physical facility and surrounding area, security considerations, staffing information, and environmental controls, including cold chain management.

Network of dispensing/administration sites: The jurisdiction-specific list of all sites where the targeted population can receive medical countermeasures, whether dispensing of pills or vaccine administration. Dispensing/administration sites are considered receiving sites, more specifically end receiving sites.

Network of receiving sites: The jurisdiction-specific list of all receiving sites, such as the list of distribution sites plus the list of dispensing/administration sites. The distribution sites are used for the management and transport of medical materiel. The dispensing/administration sites are used for the purpose of giving medical countermeasures to the targeted population. Together, all the distribution site and all the dispensing/administration sites constitute a network of receiving sites.

Pandemic influenza alert level: Pandemic influenza phases reflect the World Health Organization's risk assessment of the global situation regarding each influenza virus with pandemic potential that is infecting humans. These assessments are made initially when such viruses are identified and are updated based on evolving virological, epidemiological, and clinical data. The phases provide a high-level, global view of the evolving picture.

Partners and stakeholders: As referenced throughout the capabilities, partners and stakeholders refer to the diverse array of groups and individuals that public health agencies should engage to support the preparedness and response needs of the whole community. Many different kinds of communities, including communities of place, interest, belief, and circumstance can exist both geographically and virtually, such as online forums. A whole community approach attempts to engage the full capacity of the private and nonprofit sectors, including businesses, coalitions, faith-based organizations, disability organizations, and the public, in conjunction with the participation of federal, state, local, tribal, and territorial governmental partners.

Personal protective behaviors: Personal behaviors to prevent the transmission of infection, such as coughing into your elbow, cover sneezing, hand washing, and keeping your hands away from your face.

Ports of entry: Places where persons and goods are allowed to pass into and out of a country, such as airports, water ports, and land border crossings, and where U.S. Customs and Border Protection officers are stationed to inspect or appraise imported goods.

Postmortem: Done, occurring, or collected after death.

Preparedness cycle: A continuous cycle of planning, organizing, training, equipping, exercising, evaluating, and taking corrective action in an effort to ensure effective coordination during incident response. This cycle is one element of a broader National Preparedness System to prevent, respond to, and recover from natural disasters, acts of terrorism, and other disasters.

Priority resource element: For the purposes of this document, resource elements identified as priorities are potentially the most critical for completing capability tasks based on jurisdictional risk assessments and other forms of community input. These resource elements are relevant to both routine public health activities and essential public health services.

Procedures in place: For the purposes of this document, this phrase refers to documented agreements or processes, such as a written plan, a policy, a memorandum of understanding or agreement, a contract, or any other type of written agreement that verifies that a procedure is formally in place.

Proficiency testing challenges: Determines the performance of individual laboratories for specific tests or measurements to monitor the laboratories' continuing performance. Along with requirements for personnel qualifications and quality control testing, proficiency testing is one of the central safeguards of laboratory quality under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 and its regulations.

Psychological first aid: A set of skills that helps community residents care for their families, friends, neighbors, and themselves by providing basic psychological support in the aftermath of traumatic events.

Public health system: Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services. The public health system includes

1. Public health agencies at state and local levels
2. Health care providers

3. Public safety agencies
4. Human service and charity organizations
5. Education and youth development organizations
6. Recreation and arts-related organizations
7. Economic and philanthropic organizations
8. Environmental agencies and organizations

Quarantine: The separation and restriction of movement of people who were exposed to a contagious disease to see if they become sick.

RealOpt©: A software enterprise system that consists of various decision support capabilities for modeling and optimizing the public health infrastructure for all hazard emergency response and has been used in the areas of biological or radiological terrorism preparedness, infectious disease outbreaks planning, and natural disasters response. RealOpt© allows users to enter different parameters into the system to support planning for resource allocation within medical facilities. The enterprise system consists of stand-alone software and decision support systems.

Receipt, stage, store (RSS) facility: Acts as the hub of the distribution system of the state or local jurisdiction to which SNS assets are deployed.

Receive: For the purposes of Capability 8: Medical Countermeasure Dispensing and Administration, this term refers to taking receipt of medical materiel on behalf of the dispensing/administration site. For the purposes of Capability 9: Medical Materiel Distribution and Management, this term refers to taking receipt of medical materiel on behalf of the jurisdiction.

Recovery Support Functions (RSFs): A coordinating structure for key functional areas of assistance in the National Disaster Recovery Framework (NDRF). Their purpose is to support local governments by facilitating problem solving, improving access to resources, and fostering coordination among state and federal agencies, nongovernmental partners, and stakeholders. The six RSFs include

1. Community Planning and Capacity Building (CPCB) Recovery Support Function
2. Economic Recovery Support Function
3. Health and Social Services Recovery Support Function
4. Housing Recovery Support Function
5. Infrastructure Systems Recovery Support Function
6. Natural and Cultural Resources Recovery Support Function

Reference laboratories: LRN reference laboratories are responsible for investigation or referral of specimens. They are made up of more than 150 state and local public health, military, international, veterinary, agriculture, food, and water testing laboratories. In addition to laboratories located in the United States, facilities located in Australia, Canada, the United Kingdom, Mexico, and South Korea serve as reference laboratories abroad.

Regional distribution site (RDS)/local distribution site (LDS): A site or facility selected to receive medical countermeasures from the RSS facility for apportionment and distribution to determined dispensing sites, such as PODs.

Responders: Any individual responding to the public health task or mission, as determined by the jurisdiction. For the purposes of Capability 14: Responder Safety and Health, responders are defined as public health agency personnel. Dependent on the jurisdiction, the definition of responder may also include first receivers in the form of hospital and medical personnel.

Sample: For the purposes of the capabilities document, this term is used generally to refer to anything that can be termed a sample or specimen for testing or analysis.

Secure Access Management Services (SAMS): A CDC portal that allows public health partners and providers to access information and computer applications operated by CDC. Some of the applications or information made available through SAMS may be sensitive or non-public. The SAMS Partner Portal is one of the ways CDC controls and protects this information. For access to SAMS,

users must register online and be approved by a CDC program administrator. In cases where you might be exposed to non-public information, you may also be required to provide proof of your identity as part of your registration.

Sentinel laboratories: LRN sentinel laboratories play a key role in the early detection of biological agents. Sentinel laboratories provide routine diagnostic services, rule-out, and referral steps in the identification process. While these laboratories may not be equipped to perform the same tests as LRN reference laboratories, they can test samples.

Service animal: Any guide dog, signal dog, or other animal individually trained to provide assistance to an individual with a disability including guiding individuals with impaired vision, alerting individuals with impaired hearing to intruders or sounds, providing minimal protection or rescue work, pulling a wheelchair, or fetching dropped items.

Situational awareness: Capturing, analyzing, and interpreting data to inform decision making in a continuous and timely cycle. National health security calls for both routine and incident-related situational awareness. Situational awareness requires not only coordinated information collection to create a common operating picture (COP), but also the ability to process, interpret, and act upon this information. Action, in turn, involves making sense of available information to inform current decisions and making projections about likely future developments. Situational awareness helps identify resource gaps, with the goal of matching available and identifying additional resources to current needs. Ongoing situational awareness provides the foundation for successful detection and mitigation of emerging threats, better use of resources, and better outcomes for the population.

Social connectedness: For the purposes of Capability 1: Community Preparedness, social connectedness refers to the personal relationships, such as family, friend, and neighbor, and professional relationships, such as service provider or community leader, among community residents. It is a core component that is integral to the community's ability to marshal resources, communicate with residents, and plan for infrastructure and human recovery.

Social distancing: Within the workplace, social distancing measures could take the form of

- Modifying the frequency and type of face-to-face employee encounters, such as placing moratoriums on hand-shaking, substituting teleconferences for face-to-face meetings, staggering breaks, and posting infection control guidelines
- Establishing flexible work hours or work sites, such as telecommuting
- Maintaining three-feet spatial separation between individuals
- Implementing strategies that request and enable employees with influenza to stay home at the first sign of symptoms

Special Event Assessment Rating (SEAR): A DHS system that rates events. DHS requests jurisdictions to submit all event data, from which an algorithm is used to rate the risk from Tier I to Tier V, with Tier I being the highest and with Tier V being the lowest. SEAR events are specifically below the level of National Special Security Events. The majority of these events are state and local events that may require additional support from the federal government.

Spontaneous volunteers: Unaffiliated or unregistered volunteers with known participating volunteer organizations during an incident or event.

Stafford Act: A United States federal law designed to bring an orderly and systematic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. The Stafford Act was signed into law on November 23, 1988, as an amendment to the Disaster Relief Act of 1974 (Public Law 93-288). The Stafford

Act constitutes the statutory authority for most federal disaster response activities, especially as they pertain to the FEMA and FEMA programs, and gives FEMA the responsibility for coordinating government-wide relief efforts.

Throughput: The number of people receiving medical countermeasures at a POD during a certain period of time. For example, if 6,000 people visit a POD over a 12-hour operational period, then the throughput is 6,000 persons/12 hours = 500 people/hour.

Vaccine Adverse Events Reporting System (VAERS): A national early warning system established in 1990 to detect possible safety problems in U.S.-licensed vaccines. VAERS is co-managed by CDC and FDA. VAERS accepts and analyzes reports of adverse events (possible side effects) after a person has received a vaccination. Anyone can report an adverse event to VAERS. Health care professionals are required to report certain adverse events and vaccine manufacturers are required to report all adverse events that come to their attention.

Virtual structure: A software solution, such as WebEOC or a just-in-time modular "go kit" style solution, to create virtual or remote connections among emergency responders and other relevant stakeholders during emergency operations.

Volunteer reception center (VRC): An operation in which spontaneous, unaffiliated disaster volunteers are registered and referred to local agencies to assist with relief efforts.

World Health Organization (WHO) public health emergencies of international concern (PHEIC) declarations: Defined in the International Health Regulations (IHR) (2005) as an extraordinary event that is determined

- To constitute a public health risk to other states through the international spread of disease
- To potentially require a coordinated international response

This definition implies a situation that is serious, unusual or unexpected; carries implications for public health beyond the affected state's national border; and may require immediate international action.

Written agreements: For the purposes of the capability standards, written agreements may refer to MOUs, contracts, or other letters of agreements used at the discretion of the jurisdiction.

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Notes

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