Appendix F

APPENDIX F

Survey Instrument: Including Summary Statistics of All Close-ended Responses, and Full Text of All Open-ended Responses

Self-Assessment

SA1: The self assessment serves as a useful tool for identifying areas that need improvement.
- 65 respondents (36.1%) Strongly Agree
- 89 respondents (49.4%) are Inclined to Agree
- 11 respondents (6.1%) Neither Agree nor Disagree
- 11 respondents (6.1%) are Inclined to Disagree
- 3 respondents (1.7%) Strongly Disagree
- 1 respondents (0.6%) did not respond to this statement

SA2: The self assessment process is useful in preparing for the on-site review.
- 78 respondents (43.3%) Strongly Agree
- 74 respondents (41.1%) are Inclined to Agree
- 12 respondents (6.7%) Neither Agree nor Disagree
- 12 respondents (6.7%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

SA3: The self assessment process is a catalyst for pre-review consultation.
- 56 respondents (31.1%) Strongly Agree
- 80 respondents (44.4%) are Inclined to Agree
- 25 respondents (13.9%) Neither Agree nor Disagree
- 14 respondents (7.8%) are Inclined to Disagree
- 4 respondents (2.2%) Strongly Disagree
- 1 respondents (0.6%) did not respond to this statement

SA4: The self-assessment process:
- Can be improved by a longer assessment period. – 50 respondents (27.8%) agreed
- Can be improved by a shorter assessment period. – 17 respondents (9.4%) agreed
- Needs no improvement. – 53 respondents (29.4%) agreed
- Should be discontinued. – 11 respondents (6.1%) agreed
- Other. – 43 respondents (23.9%) provided other comments (see below).
- 6 (3.3%) respondents did not respond to this statement

SA4a: Open-ended Comments: Please describe 'Other' from the preceding question:
- It serves a purpose, but the "right" people are not always made privy to the process until it's too late to adequately act on the needed changes prior to the site visit.
- The problem, as I see it, with the self-assessment process is that many indicators are open to interpretation (LHD's vs. State's). All the self-assessment in the world will not help if the LHD's aren't clear on what the specific expectations are.
- Assign assessor for each Section. Site visit at beginning by assessor for each Section. Assessor serves as designated liaison and as final review person.
- Be more specific by indicating exactly what will be expected.
- Although the self-assessment process is helpful, it is very costly to Local Public Health. If it is going to be required there should be state funding provided to cover the costs.
- The same tool should be used for the entire cycle and then evaluated.
- The problem arises when the "rules" change midway through the process.
- The self-assessment needs to include information to staff as to what the process is about, what is expected, what the long-term ramifications are for having or not having accreditation.
- Can be improved by agencies having an assessment process that mirrors the process a reviewer uses, coupled with self-assessment training.

- 1. The self-assessment needs to be an ongoing quality control procedure.
  2. LHD's tend to avoid exposing their weaknesses to evaluators in advance of the review. All indicators are typically marked "Fully Met". I find no value as a reviewer to the present self-assessment format.
  3. The following procedure may have value: a) LHD's submit self assessment to MPHI - not to State Agencies - in advance of the review. b)The self-assessment and the evaluators findings are compared/discussed at the exit interview
- We provide our programs with a detailed Accreditation Guidance Document that specifically lists the documentation needed to meet each indicator. Staff from our program have told us how helpful this document is for the self-assessment and the on-site review.
- The self-assessment tool itself needs to be improved. It is not just a matter of whether self-assessment is proper or the length of time needed, but to have a good tool. The tool was not definitive enough for many program areas and that goes back to the fact that the MPR's and what was needed to meet an MPR was not defined in a great enough detail to provide any real assistance. Revise the tool, not the entire process. The tool needs to be clear and accurate regarding what needs to be in place to meet the MPR's. But the self-assessment should be internal to the organization being reviewed and not necessarily reviewed by the State. The State should be available to answer questions and assist in understanding the tool.
- More detail for what is expected to fulfill the indicator. Such as use the site-review tool.
- Self-Assessment, technical assistance - resources were very difficult to contact to get answers to questions. The guidance did not always match the advice of the resource or of the reviewer who came on-site.
- Self assessment is an excellent tool only if used for in house purposes and not shared with the state. If the expectation is that it will be shared in the future then self-assessment should be discontinued.
- The process is OK, but the tool used for the self-assessment should be the same tool that is used for accreditation--changes to standards should not be made at the last minute with the expectation that local health departments can meet the changed standard.
- More detailed, maybe include some samples
- Should still be provided as a tool but not submitted for review.
- Tool is useful internally, but need not be submitted.
- Should be used as the local agency sees fit in ongoing activities to assure that their agency meets the standards.
- I think the length of time given for the survey is appropriate. I would not, however, say that the process "needs no improvement" as that is a very different matter. Almost anything can be improved.
- The self-assessment is a quality assurance tool and is useful in the ongoing process of program improvement but submission should not be required prior to the accreditation review.
- The questions were answered assuming that the self-assessment tool would be utilized as an internal document, should not be sent to the accrediting body.
- Current, up to date versions should be available before initiating the process with LHDs.
- The assessment tool can be useful for identifying needs, however, it should not have to be sent to MPHI before the actual survey.
- Eliminate the need to return the SA to the State. Rather, let it be a local tool.
- Is the self-assessment tool a necessary or effective tool? In both the first and second round local health departments rarely marked anything as "not met" even when it was likely evident that multiple portions of the program were not met and proved to be with the assessment process. If this is a tool that is to continue, it needs to be asked whether there is sufficient understanding of the intent of the tool and/or where does it go from here? Perhaps this should be changed to be an internal preparation tool only for the local health department that is not required to sent to MPHI, MDA or MDEQ.
- My role is that of an Accreditation Reviewer. However, based on past experience at the LHD level I feel that the self-assessment aspect was very helpful at the beginning of the entire accreditation process in Cycle One. Unless there are major changes in the indicators for each cycle, I am uncertain whether or not self-assessment is necessary. For the most part I believe this aspect is a LHD decision.
- The self-assessment needs to be reviewed with the individuals that prepared it. There was too much self interpretation and not what was intended.

- Could be replaced with providing the assessment tool instead.
- Better Interpretation of the indicators both as LHD staff and MDCH reviewers.
- Although it is useful in preparing, it is open for interpretation and is not always followed consistently, even by the reviewers.
- I don't believe the "time-line" is a factor. Perceptions are very tricky. Unless someone has gone through the tool in a detailed fashion and can ask the right questions, conclusions vary
- Would like to see the Guidance Document formatted to one indicator per page with the next indicator beginning on a new page. We create binders to address one indicator at a time. It would also be helpful to know what changes there have been since the last document we used. When we reused the binders from the first round, had to search every indicator and word for changes.
- Provide "current" standards in a timely manner. The document was changing regularly and we were using 2000 standards for a 2001 review and several sections changed.
- Should make it "optional" for local health department internal use only (i.e., no requirement for submission to MPHI and State agencies).
- The self-assessment should be used as a tool, but submission should not be required.
- As a reviewer, it is difficult to know the benefits and value of the self-assessment. For the most part, LHDs indicated that all indicators were met on the self-assessment for my section, and yet this wasn't always the case.
- Can be improved by appropriate user incorporation as a tool of quality improvement and coupled with earlier engagement of technical assistance resources.
- Notify LHDs that the tools are on the website; strongly encourage them to review the tool and conduct a self-assessment then contact respective programs if technical assistance is needed.
- Some LHD's are very detailed in responses to unmet indicators while others are not. Does the self-assessment process really prepare the local health department for the on-site review? What type of documentation or consultation would prepare a local health department?
- Different time of the year. This is the most difficult time to do...grant, program plans often have May, June as their deadlines. Do In FEB!
- Should be briefer in terms of the reporting requirements; providing an overview for each section.
- Should be optional for LHD to use as internal planning tool
- Self-Assessment is very important however I did not like the tool and utilized the assessment tool itself.
- Should be provided prior to the start of the fiscal year to allow evaluation and adjustment as necessary
- Improved by providing additional support from a peer organization that can offer useful suggestions on assessment.
- Consultation with agencies on what the indicators mean.
- This can be a very productive tool in preparing the agency for accreditation. However, the information received is not always reflective of the agency process. A system that allows a candid review without concerns of consequences is needed. It may mean just explaining or re-explaining that this self-assessment process is an opportunity for the agency to identify areas that they may require consultation in prior to the review. Having the agencies input on what would be a hopeful process is also vital. Now it appears to be more a task of compliance than the beginning of a consultation process.
- Why does the self-assessment form need to be turned in to MPHI?
- I believe 6 months period of time is adequate; as long as the tool will still be available from the web each January. I would hate to {*go*} into the on-site review blind.
- Shouldn't be part of the state's component; each agency should determine the most efficacious self-assessment process for itself.

<u>On-Site Review</u>

OSR1: The on-site review process can be improved by LHD evaluation of state agency reviewers.

- 97 respondents (53.9%) Strongly Agree
- 57 respondents (31.7%) are Inclined to Agree
- 17 respondents (9.4%) Neither Agree nor Disagree
- 4 respondents (2.2%) are Inclined to Disagree
- 3 respondents (1.7%) Strongly Disagree

- 2 respondents (1.1%) did not respond to this statement

OSR2: The on-site review process can be improved by increased use of exit interviews.
- 112 respondents (62.2%) Strongly Agree
- 44 respondents (22.4%) are Inclined to Agree
- 15 respondents (8.3%) Neither Agree or Disagree
- 6 respondents (3.3%) are Inclined to Disagree
- 0 respondents Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

OSR3: The on-site review serves as an opportunity for constructive program related dialogue between LHD staff and review staff.
- 74 respondents (44.1%) Strongly Agree
- 55 respondents (30.6%) are Inclined to Agree
- 16 respondents (8.9%) Neither Agree nor Disagree
- 25 respondents (13.9%) are Inclined to Disagree
- 7 respondents (3.9%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

OSR4: Program reviews have good understanding of the accreditation standards.
- 30 respondents (30.7%) Strongly Agree
- 69 respondents (38.3%) are Inclined to Agree
- 36 respondents (20.0%) Neither Agree or Disagree
- 40 respondents (22.2%) are Inclined to Disagree
- 4 respondents (2.2%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

OSR5: All reviewers within a program apply the accreditation standards the same way.
- 13 respondents (7.2%) Strongly Agree
- 21 respondents (11.7%) are Inclined to Agree
- 13 respondents (7.2%) Neither Agree or Disagree
- 68 respondents (37.8%) are Inclined to Disagree
- 64 respondents (35.6%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

OSR6: The same program reviewer applies the accreditation standard the same way at each LHD.
- 22 respondents (12.2%) Strongly Agree
- 23 respondents (12.8%) are Inclined to Agree
- 61 respondents (33.9%) Neither Agree nor Disagree
- 42 respondents (23.3%) are Inclined to Disagree
- 31 respondents (17.2%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

OSR7: The presence of a program specific local public health peer reviewer would improve the on-site review process.
- 43 respondents (23.9%) Strongly Agree
- 73 respondents (40.6%) are Inclined to Agree
- 48 respondents (26.7%) Neither Agree nor Disagree
- 13 respondents (7.2%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 1 respondents (0.6%) did not respond to this statement

<u>On-Site Review Report</u>

OSRR1: The on-site review report assists the LHD as a tool for performance improvement.
- 59 respondents (32.8%) Strongly Agree

- 86 respondents (47.8%) are Inclined to Agree
- 15 respondents (8.3%) Neither Agree nor Disagree
- 18 respondents (10.0%) are Inclined to Disagree
- 1 respondent (0.6%) Strongly Disagrees
- 1 respondent (0.6%) did not respond to this statement

OSRR 2: The on-site review report would be improved by more frequent use of the special recognition section.

- 39 respondents (21.7%) Strongly Agree
- 63 respondents (35.0%) are Inclined to Agree
- 57 respondents (31.7%) Neither Agree nor Disagree
- 17 respondents (9.4%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

OSRR 3: The on-site review report would be improved by more frequent use of the recommendations for improvement section.

- 42 respondents (23.3%) Strongly Agree
- 84 respondents (46.7%) are Inclined to Agree
- 41 respondents (22.8%) Neither Agree nor Disagree
- 10 respondents (5.6%) are Inclined to Disagree
- 1 respondent (0.6) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

Corrective Plans of Action

CPA1: The corrective plan of action services as a useful mechanism for continuous improvement.

- 42 respondents (23.3%) Strongly Agree
- 89 respondents (49.4%) are Inclined to Agree
- 26 respondents (14.4%) Neither Agree nor Disagree
- 16 respondents (8.9%) are Inclined to Disagree
- 5 respondents (2.8%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

CPA2: The CPA process can best be improved by a shorter time frame for implementation.

- 19 respondents (10.6%) Strongly Agree
- 29 respondents (16.1%) are Inclined to Agree
- 46 respondents (25.6%) Neither Agree nor Disagree
- 74 respondents (41.1%) are Inclined to Disagree
- 10 respondents (5.6%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

CPA3: The CPA process would benefit from improved communication between program reviewers and LHD staff.

- 76 respondents (42.2%) Strongly Agree
- 71 respondents (39.4%) are Inclined to Agree
- 29 respondents (16.1%) Neither Agree nor Disagree
- 1 respondent (0.6%) is Inclined to Disagree
- 2 respondents (1.0%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

The following open-ended comments were suggested, when asked how the CPA process can best be improved (CPA4):

- LHD technical staff should bend over backwards to help LHD's become fully accredited.
- Consistent follow up from program reviewers once they receive the CPA. We never did hear from anyone again.
- Improved consultation and response time frames once corrective action is complete. Each state program responds differently...and basically state they don't care how others respond.

- A shorter time frame for re-evaluation from the reviewer once the CPA is complete.
- I did not have to write any for the sections I was responsible for so I have no idea!
- An unbiased private 3rd party should perform on-site review with experience in evaluations. They should not be comprised of state employees or LHD representation. Exit interviews are essential and it should be mandated that all LHD management and affected employees be present for all exit interviews. It should be mandated that the exit interviewing staff be required to leave a list of draft issues at the time of departure and that the list not change from what comes in the mail later. I don't believe anyone has a clear understanding of what the accreditation standards are, how they are formally adopted with LHD representation and how they are modified or interpreted. How can an on-site report assist LHDs as a tool for performance improvement if they don't agree with the standard? A bigger carrot (more frequent use of special recognition) is not going to improve the process. Recommendations are useless unless all parties have had involvement in their development and agree in their importance. The CPA process is very time consuming and costly to implement and MALPH must be certain they agree with those MPRs which would require a CPA for compliance.
- Provide the CPA from other LHDs so that all LHD can benefit from the problem solving efforts of other LHDs.
- Taking the LHD's unique situations into consideration; some indicators are difficult to meet in some LHD's because of fixed variables. At this time, the CPA process is nothing more than a mechanism to force compliance, not self-improvement. Perhaps the problem lies in the root of the CPA process; the indicators themselves. Are Agencies unable to set their own standards/goals/reasonable expectations within a framework of options and guidelines?
- Eliminate it.
- Unfortunately your questions lump all programs together. There are major differences in how accreditation review is handled by each respective agency. For example MDEQ handling was arrogant and pompous, while MDA review was inclined to be helpful and encouraging.
- The CPA process should always cover a short time frame. Long term planning is an internal LHD responsibility.
- Follow-up by agencies after the review to discuss improvements once the report has been reviewed and the stress of the evaluation period is gone.
- Timely results of review provided to LHD, otherwise it worked fine. Suggest one standard follow-up format or document for the rechecks. Separate reporting by reviewers following the rechecks resulted in too many letters. Develop a document that tracks all not met indicators and results of follow-ups with sign-offs when met.
- Perhaps a guide for the development of CPAs would be helpful. The guide should define specific elements that need to be included in a CPA - such as:
  a) Statement of the present condition (i.e., 47% of the establishments are being inspected at the required frequency).
  b) Statement of the standard (i.e., All establishments are required to be inspected once every six months)
  c) Statement of how the problem will be controlled along with the necessary records and names of the responsible personnel. The statement should also include training needs.
  d) Statement of how the CPA will be monitored to make certain the plan is being properly carried out and on time.
  e) Statement to indicate the corrective action that will be taken should problems be noted during the monitoring process.
  f) Statement to define how/when the LHD will judge whether or not the CPA has been fully implemented and is ready to ask the State agency to provide verification.
- There needs to be a clear understanding of what needs to be improved or changed to meet an MPR. It is important that there be open dialogue between the LHD and the State Program reviewers if the proposed corrective action plan will be sufficient and adequate to correct the problem noted during the review. This is needed prior to submittal of the corrective action plan, after the corrective action plan is reviewed and approved and prior to the re-evaluation. Having MPHI staff involved causes delays, confusion and communication errors. All responses should be made directly to the program staff and not through MPHI.
- If the reviewer would outline what they are expecting for a CPA at the time of the exit interview.
- Results and other feedback in a more timely fashion.
- Better identification of the steps and status of submitted CPAs.

- Assuring standardized review of specific program end requirements so we know exactly what needs to be done to get into compliance. Vaguely or ambiguously written qualitative statements describing deficiencies make development of the CPA difficult and almost impossible to know when you have put a correction in place that will meet the requirement.
- Program reviewers recommendations are many times vague. Tell us exactly what you want. Give examples or provide us with the plate language and let us fill in the detail that is specific to our department. Why should we all have to re-invent the wheel?
- Collaboration between the reviewer and the health department to come to a common agreement of what really needs to be improved versus the reviewer's opinion or recommendation of what they would like to see happen "in the perfect world".
- Consolidation of the CPA review findings report/acceptance of corrective action plan being completed and sent back as a package.
- There should not be so much time {*between*} the corrective plan of action and the review.
- The state should fund a 3rd party to work with the LHD until the improvements have been made and everyone understands the standard desired.
- Better follow up with the local HD. Time frames should be much shorter. 1 month for a plan, 3 - 6 months for implementation. More time does have to be allowed if the item is a monetary issue.
- Continued selection of quality and effective reviewer to carry out the process.
- Assistance from MDCH in implementing CPA changes.
- Clear outcomes and timeframes being specified.
- This is a budget issue!
- assuring state funding for improvements that the state is requiring; and by NOT threatening to cut off state funding if full compliance hasn't been achieved by a date certain.
- This process is not functional as is. Currently, the LHD can prepare a CPA and submit for review and approval and resubmit should it not be accepted. A check off template should be used for consistency and to make certain that what some LHD's call "MPR creep" is not being required by different state agency reviewers and or divisions.
- Making it clear that state consultants are there to help the LHD comply with standards rather than as purely assessors.
- Better defined performance measure standards so there is less variance between reviewers.
- Education of both reviewers and LHD staff on purpose and roles and responsibilities of each.
- The LHD are held to specific CPA time frames, so should the reviewing body.
- A clearly written guideline and a willingness of the program reviewer to work on a CPA.
- Reinforcing the linkage between the good or consistent use of recommendations for improvement, even when it's a "met" component. It needs to be emphasized that the recommendations, which often go beyond the reason for being "not met", are included in the CPA.
- CPAs are intended to address the "not met" indicators only. There should be some provision for incorporating recommendations for improvement for "fully met" indicators into the CPA.
- A face to face review of corrective action plan and a continuous progress update
- The reviewer needs to take into consideration the LHD jurisdictional issues, economics, political atmosphere, and demographics
- Maintaining consistency with reviewers and being more straightforward with the indicators so that there is no room for interpretation.
- Obtaining feedback from state reviewers on quality of CPA, as submitted, independent of what occurred in on-site review would be more meaningful.
- In some programs, the expectations of the reviewers were vague or not articulated to the listeners understanding. The responses were not always clear on whether "the CPA is great- you're approved--letter sent" or "the CPA is approved - we will need to see or review the progress before sending a letter."
- Shortening the process.
- Having good communication with key contacts at the State to assure thorough understanding at the local level of expectations.
- The LHD and evaluator discussing and trying to reach a consensus on the components of an appropriate CPA during an exit meeting at the end of the on-site evaluation.
- Giving exact instructions on how to make corrections and allowing then just one follow-up by the accreditation team, if necessary.

- Assist us with references and rationale and assistance toward improvement. Some of the reviewers were terrific and saw the accreditation process as a way of assisting us in maintaining the high standards that we expect of others and ourselves. I especially found the pre-reviews helpful - the staff was willing to work with us in the program. I did not find all the reviewers punitive, but when the process began, there was one who was but as I worked with them/her, things improved. I think it is really important for the accreditation staff to see themselves as helpful - we all tend to be too defensive if we pick up that they are defensive.
- Earlier and more constructively active engagement between reviewing programs and LHD staff to rectify outstanding discrepancies.
- Reviewers providing information on best practices for areas not meet and other LPH resources who have good programs
- (1) Rename this process to the Corrective Action Plan (CAP)-to describe the document/improvement plan better. (2) The CPA should be submitted directly to the program and each program reviewer should immediately begin communication with the LHD to implement the CPA. By a set deadline, programs should report a recommendation for Accreditation, Non-Accreditation, etc. to the Commission (via an electronic, password protected web page on a website (MPHI's, MALPH's or State of MI). Deadline reminders can be sent electronically to reviewers or personal follow-up if necessary.
- Shortening the time frame for indicators/CPA's does not benefit the LHD. Communication with reviewer and MDCH staff is valuable.
- Look at systems; not criteria.
- Clear communication of expectations once CPA is approved.
- Communication with LHD about problems with programs prior to accreditation review process, plus base current review on past 3 years only rather than past/historical problems.
- Sharing of 'best practices' specific to a LHD's 'not-met'-area by peers from LHDs that were commended by reviewers in that area.
- Review staff providing guidance in the development of the CPA.
- Focus on overall program operations to adjust for corrections needed - piecemeal correction schedule leads to erratic program function and inefficiencies.
- Developing ways to ensure that CPA actions are sustained rather than just completed for accreditation and then allowed to deteriorate.
- A more collaborative effort between the State Departments and the Local Health Departments looking at all aspects of the perceived deficiencies.
- The current process of allowing the reviewer and the agency work through what is needed to meet the criteria is good. I am not sure that the LHD understands that this process will differ by programs. To the extent possible, having some consistency in programs during the CPA process and clearing outlining to the LHD what they can expect by programs will help in the confusion.
- Being more flexible in implementation especially when a department is short staffed.
- We had very few corrections to make, so I thought the process was okay. It did bother me that my sister county had the exact same indicator incorrect with the same wording written and yet the CPA was different.
- Not holding agencies responsible for measures that are outside of their control, as in MCIR percentages. The measure should relate to the agencies MCIR percentages.
- A team effort between the reviewer and LHD in preparing the CPA would work nicely. Discussions/revisions as the CPA is being written would produce a plan that is workable in the LHD and acceptable by the State.
- More dialogue from the LHD's. Too many times there is nothing between the agencies, and when the CPA is submitted there could be problems in which prior contact and working relationship could prevent some of these issues.

<u>Accreditation Tool</u>

Tool1: The accreditation tool should focus more on achievable optimal performance standards rather than minimum program requirements.

- 33 respondents (18.3%) Strongly Agree
- 49 respondents (27.2%) are Inclined to Agree
- 27 respondents (15.0%) Neither Agree nor Disagree
- 46 respondents (25.6%) are Inclined to Disagree

- 23 respondents (12.8%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

Tool2: The designation "Accreditation with Commendation" is reflective of enhanced program capacity.

- 44 respondents (24.4%) Strongly Agree
- 69 respondents (38.3%) are Inclined to Agree
- 33 respondents (18.3%) Neither Agree nor Disagree
- 27 respondents (15.0%) are Inclined to Disagree
- 6 respondents (3.3%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

Tool3: The formatting of the Accreditation Tools meets user needs.

- 25 respondents (13.9%) Strongly Agree
- 58 respondents (32.2%) are Inclined to Agree
- 41 respondents (22.0%) Neither Agree nor Disagree
- 42 respondent (23.3%) are Inclined to Disagree
- 13 respondents (7.2%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

Tool4: In general, the standards in the Tool are written in a clear and concise manner.

- 19 respondents (10.6%) Strongly Agree
- 64 respondents (35.6%) are Inclined to Agree
- 28 respondents (15.6%) Neither Agree nor Disagree
- 52 respondents (28.9%) are Inclined to Disagree
- 16 respondents (8.9%) Strongly Disagree
- 1 respondents (0.6%) did not respond to this statement

Tool5: The accreditation tool is a useful mechanism for annual LHD program planning activities.

- 26 respondents (14.4%) Strongly Agree
- 62 respondents (34.4%) are Inclined to Agree
- 42 respondents (23.3%) Neither Agree nor Disagree
- 36 respondent (20.0%) are Inclined to Disagree
- 13 respondents (7.2%) Strongly Disagree
- 1 respondent (0.6%) did not respond to this statement

Technical Assistance/Website

TA1: The current technical assistance resource, as specified in the Accreditation Tool, contributes to the quality improvement of local public health programs.

- 15 respondents (8.3%) Strongly Agree
- 42 respondents (23.3%) are Inclined to Agree
- 80 respondents (44.4%) Neither Agree nor Disagree
- 30 respondents (16.7%) are Inclined to Disagree
- 8 respondents (4.4%) Strongly Disagree
- 5 respondents (2.8%) did not respond to this statement

TA2: Technical assistance can best be improved by (open-ended comments below):

- Active sharing of best practices.
- LHD's don't seem to use it frequently based on my experience.
- Consistent responses regardless of program assisting. Some are helpful, some are useless.
- Faster responses from the technical assistance contacts. List their e-mail addresses in addition to phone and fax numbers.
- The tool is too formal and related too much to the completion of the forms used rather than the contents of the forms.
- The "devil" is in the details. The current technical assistance documents, etc., leave out the evaluation details that MDEQ and MDA addresses in their respective evaluations. Manuals are in

order. Some were developed long after the evaluation process started. Much too late to help in the first round.

- More consistency among response.
- A year-round close working relationship with the State program consultant(s) needs to be maintained. The notion that both the State and the LHD have an important stake in providing quality service needs to be at the forefront. Quality is a team effort. The State has its role, as does local health.
  Perhaps a State agency service evaluation component could be included in a review. Ask LHDs (MALPH) to provide an outline of desired state technical services for each program. Provide a list of the services the State consultant has actually either provided or offered during the review period. The service evaluation may encourage both the LHD and State consultant to keep the lines of communication open and prevent some agencies from being neglected.
- Not all LHD staff utilize the technical assistance form or website. Most staff simply call one of the reviewers for clarification. I am not certain if all LHD staff are aware of the correct procedures for technical assistance.
- Until you improve how you communicate to LHD's what is acceptable to meet an MPR any technological use of garbage is still garbage.
- There needs to be a process for quick responses from Technical Assistance back to LHD.
- Shifting focus of TAs from one of offering guidance on how best to respond to a particular measure to one of contributing to the overall program QI.
- Stress to LHDs to review answers posted on website prior to requesting Tech assistance, we seem to get the same questions and we refer LHDs to website for answers.
- Telling people how the reviewers will evaluate standards, as there seems to be a lot of variation between what is written and what is expected.
- Having someone either trained at the LHD level or provided by the state to work in the field to achieve standards.
- Accessibility, links to materials and best practice models from other LHDs.
- Ensuring that responsive, knowledgeable people provide the TA.
- No matter what phase of improvement a LHD is in encouragement and direction is needed for program progression not a “you are in trouble” mentality. Help, effective communication and hands on assistance may be needed.
- Changing the attitude of the providers of technical assistance from that of accreditation "police" to "helpers"
- Limited use of the site, hard to make assessment of the value or of ways to improve.
- Providing clearly stated indicators that are not subject to subjective interpretation. Keep the same indicators through at least 1 accreditation cycle.
- Some people were great to work with and others were rude and/or vague.
- Keeping information (i.e., phone numbers, personnel) accurate/up to date.
- Making certain that section contact people and phone numbers are current/accurate.
- Consistency/updates in individuals responsible.
- Making state evaluators and MPHI staff accessible to LHD for advice, guidance, feedback, etc.
- Responding to LHD questions.
- Keeping it up to date and having the consultant available for questions. I was not particularly impressed with MPHI's commitment.
- Assuring that individual programs provide regular on-going training targeted to compliance with MPRs and suggested best practices for program enhancement.
- Assuring that Reviewers are good communicators...That they are enthused about their jobs and understand LPH.
- Do not contract with an outside agency such as MPHI to do accreditation. This limits the resource ability, and consultation ability of this experience to improve local public health. It is very frustrating to have a black and white responder who really doesn't understand the concept or question.
- I would like to see the accreditation staff make site visits and go over the standards with us and answer our questions. However, when we work on it, they are usually responsive to my questions.
- Making on-site visits, as needed, during the three year interim between formally scheduled Accreditation visits.

- Coordinated training of TA contacts in order to synthesize those encounters into a more usable and valuable "web-based" resource.
- Information on Best Practices.
- Eliminate the paper form for technical assistance. Allow the form to be sent to the TA via e-mail.
- Greater responsiveness of TA staff.
- For the most part, some programs not so great.
- Providing regional person that has knowledge and experience in all local health department programs instead of program specialist in one area.
- Consistent consultation with LHDs.
- More direct, but moderated, conversation between state and local program staff over the course of every year.
- More follow up from the state with hands on help and examples of what works instead of being told something is wrong and then give no help to achieve goals of correction.
- Offering specific responses, sometimes the responses were too vague.

TA3: The accreditation program website is a value resource.

- 18 respondents (10.0%) Strongly Agree
- 49 respondents (27.2%) are Inclined to Agree
- 85 respondents (47.2%) Neither Agree nor Disagree
- 14 respondents (7.8%) are Inclined to Disagree
- 10 respondents (5.6%) Strongly Disagree
- 4 respondents (2.2%) did not respond to this statement

TA4: The accreditation program website can best be improved by (open-ended comments below):

- Search function should be improved.
- Have not seen website.
- Better promotion of its use. Providing other useful ideas, discussion, etc.
- Get rid of frames. Convert .doc files to .pdf. I had trouble viewing site..."view window is out of memory." Perhaps add a Q&A bulletin board area and a way to submit questions online.
- Must be current and information contained on it reviewed by Local Public Health and approved by MALPH.
- The website is good but personal contact is best.
- Informing LHD staff of its existence.
- Having info that is helpful, not a bunch of bureaucratic garbage.
- Updated more often.
- Site could reflect best practices, could serve as a status update for CPAs, and could be means of communicating and logging interpretive memorandums.
- Assuring that the most up to date review standards are present. It could serve as the single source for LHDs to obtain the current standards against which they will be reviewed.
- Making it easier to access. Shouldn't need a password.
- I have not utilized this resource.
- Opening its large files often causes my computer to freeze up!
- Education of the health department staff on the accreditation website.
- Putting something on it that showcases how some departments do actually do things well.
- Where is it? Is it interactive?
- Being a place where "best practice" documents can be found (i.e., policies and procedures that the state agencies agree are exemplary).
- Used the web site to obtain up to date materials, self study and accreditation tool, check on dates and to look at statewide results.
- See above dialogue box. I see a possible drift towards more subjectivity into onsite reviews. I fully support the accreditation process but you need to focus on clearly stated indicators free of subjective interpretation but perhaps less widget counting. Each jurisdiction needs to be reviewed using the same standards of interpretation. Why no dialogue box for accreditation Process?? My comment - do not expand accreditation review to other LHD Programs until you can properly fund the programs.
- We had trouble using it at times.
- Updated information for local health departments to use concerning evolving tool changes, interpretations or decisions made by MPHI or the accreditation board.

- Based on the completion of several accreditation on-site reviews there has been no indication that they utilize this website. Minimally, if the website is to remain available it should be continually updated with current information.
- Earlier access
- Keeping reviewer comments updated and current.
- It would be helpful if the website gave examples of best practices that other LHDs use and are successful. In addition, forms, templates, documents that can assist in our documentation procedures should be included on the website.
- adding direct links and contact information for reviewers. Current LHD status report like is found in the Local Liaison Reports.
- Keeping it up to date.
- Assuring that the standards are current and accurate.
- Improving the tool itself. The web site should project a measured rhythm to the accreditation process.
- Haven't used it.
- I haven't seen website except to pull the MPR off.
- Include results of other site visits with no identifying information. List of most frequently unmet indicators with information how to meet. Ability to post questions etc., for answer by other LHD.
- The accurate and timely inclusion of FAQ's and TA responses appropriate to the outstanding accreditation issues that arise.
- Insuring information is accurate and up-to-date. Information available in a document which is easy to download. Expand information on best practice
- Increase awareness of the website. Add additional items to increase usefulness; Add TA's email addresses as links; See recommendations for Self-Assessment and Corrective Plans of Action.
- Haven't used it.
- ... don't know -- I've never visited the site.
- could be but hasn't been updated in a timely manner
- Having standards available that match what you will be reviewed on (instead of old versions that are no longer relevant).
- Advertise its presence - didn't know there was one.
- Do not even know that it exists.
- No comment--easy to negotiate and find things.
- More communication on standards. Updated information. More opportunity for discussions on ways to meet standards.

Accreditation Process

AP1: The purpose of the accreditation process should be on-going quality improvement.
- 103 respondents (57.2%) Strongly Agree
- 58 respondents (32.2%) are Inclined to Agree
- 12 respondents (6.7%) Neither Agree nor Disagree
- 4 respondents (2.2%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 1 respondents (0.6%) did not respond to this statement

AP2: The purpose of the accreditation process should be contact compliance.
- 29 respondents (16.1%) Strongly Agree
- 54 respondents (30.0%) are Inclined to Agree
- 23 respondents (12.8%) Neither Agree nor Disagree
- 46 respondents (25.6%) are Inclined to Disagree
- 24 respondents (13.3%) Strongly Disagree
- 4 respondents (2.2%) did not respond to this statement.

AP3: The accreditation process reflects a set of achievable standards.
- 33 respondents (18.3%) Strongly Agree
- 74 respondents (41.1%) are Inclined to Agree
- 19 respondents (10.6%) Neither Agree nor Disagree
- 38 respondents (21.1%) are Inclined to Disagree

- 13 respondents (7.2%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

AP4: The accreditation process can be improved by increased focus on recommendations for performance improvement.

- 48 respondents (26.7%) Strongly Agree
- 76 respondents (42.2%) are Inclined to Agree
- 36 respondents (20.0%) Neither Agree nor Disagree
- 14 respondents (7.8%) are Inclined to Disagree
- 3 respondents (1.7%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

AP5: It is important for state agencies to seek funds to conduct an outside objective evaluation of the accreditation program.

- 56 respondents (31.1%) Strongly Agree
- 48 respondents (26.7%) are Inclined to Agree
- 36 respondents (20.0%) Neither Agree nor Disagree
- 28 respondents (15.6%) are Inclined to Disagree
- 9 respondents (5.0%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

AP6: Overall, the accreditation process has improved the program performance of the LHD.

- 46 respondents (25.6%) Strongly Agree
- 78 respondents (43.3%) are Inclined to Agree
- 29 respondents (16.1%) Neither Agree nor Disagree
- 19 respondents (10.6%) are Inclined to Disagree
- 6 respondents (3.3%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

AP7: The accreditation process serves as a useful internal LHD program evaluation tool.

- 42 respondents (23.3%) Strongly Agree
- 90 respondents (50.0%) are Inclined to Agree
- 20 respondents (11.1%) Neither Agree nor Disagree
- 21 respondents (11.7%) are Inclined to Disagree
- 4 respondents (2.2%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

AP8: Accreditation should be based on all state-funded services currently included in the process.

- 29 respondents (16.1%) Strongly Agree
- 66 respondents (36.7%) are Inclined to Agree
- 44 respondents (24.4%) Neither Agree nor Disagree
- 29 respondents (16.1%) are Inclined to Disagree
- 10 respondents (5.6%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

AP9: Accreditation should be based on the minimum set of services that every local health department must provide.

- 45 respondents (25.0%) Strongly Agree
- 84 respondents (46.7%) are Inclined to Agree
- 24 respondents (13.3%) Neither Agree nor Disagree
- 16 respondents (8.9%) are Inclined to Disagree
- 7 respondents (3.9%) Strongly Disagree
- 4 respondents (2.2%) did not respond to this statement

Networking

Ntwk1: The establishment of the Accreditation Peer Support Network (ASPN) would improve the accreditation process.

- 45 respondents (25.0%) Strongly Agree
- 87 respondents (48.3%) are Inclined to Agree
- 30 respondents (16.7%) Neither Agree nor Disagree
- 14 respondent (7.8%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

Ntwk2: I would seek program guidance from a peer network for the purpose of achieving accreditation.

- 53 respondents (29.2%) Strongly Agree
- 87 respondents (48.3%) are Inclined to Agree
- 20 respondents (11.1%) Neither Agree nor Disagree
- 14 respondents (7.8%) are Inclined to Disagree
- 3 respondents (1.7%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

Ntwk3: I would serve on and/or share resources with a peer network.

- 48 respondents (26.7%) Strongly Agree
- 86 respondents (47.8%) are Inclined to Agree
- 28 respondents (15.6%) Neither Agree nor Disagree
- 12 respondents (6.7%) are Inclined to Disagree
- 3 respondents (1.7%) Strongly Disagree
- 3 respondents (1.7%) did not respond to this statement

An APSN should be established and maintained by (check all that apply):

- 79 respondents indicted State agencies
- 53 respondents indicated MPHI.
- 107 respondents indicated MALPH.
- 94 respondents indicated Local Health Departments.
- 56 respondents indicated Accreditation Commission.
- 16 respondents indicated MI. Association of Public Health & Preventive Medicine Physicians (MAPPP).
- 13 respondents indicated Other.

Please describe 'Other' from the preceding question (open-ended comments below, NtWk4a):

- The basic accreditation should cover the (currently LPHO) 8 required programs and the administrative capacities areas. If other programs like WIC, Family Planning, MSS/ISS are included they should hold a separate accreditation and should not impact on the overall public health accreditation.
- Accreditation standards may be achievable but need to correlate to funding. When funding goes down, they need to go down or be reprioritized. MDEQ continues to want more & more while reducing our funding. If they want more while reducing funding they should be required to negotiate changes within their funding levels. Any recommendations for performance improvement need to be tied to funding and reviewed, negotiated and approved by MALPH. An outside objective evaluation is highly recommended. A nationally recognized 3rd party evaluator should run the accreditation program. State Departments should be spending their resources training LHDs instead of evaluating them for contract compliance.
- Not feasible until funding is provided for accreditation.
- The APSN should be a collaboration of agencies. MALPH should be the agency to establish and maintain the APSN.
- MALEHA.
- I don't have an opinion on who would be the appropriate agency to establish and maintain this network.
- Funding is needed to support agencies/individuals who are willing to participate in this process. The state Domestic Abuse group within FIA does peer review and support and provides reimbursement to individuals. This would really improve the consultation aspect of the process.

- For EH MALEHA.
- Most LHD have informal networks of peers already established. In light of budgetary constraints it is hard to imagine a "voluntary" (read uncompensated) APSN being a viable option. Funding needs to be attached to the establishment of this network to make it work for anyone!
- The above "neither agree nor disagree" answers are based on being a state reviewer not a health department staff person.
- Two questions in this category were left blank as they were not applicable to my role as accreditation reviewer. Any resource people to offer advice or council on accreditation issues should as a minimum, be comprised of state agencies and local health departments.
- Private Sector.
- I think that the peer support networking should remain an informal process. We already call other agencies for this help and it has worked very well. I would not like to see it be something more formal.
- The APSN should be maintained jointly by MALPH and State Agencies. If only maintained by MALPH, it will be disconnected from State Agencies and misguide LHDs on what State evaluators will be looking for.
- No opinion. I don't think I have much time to use or participate.
- Perhaps also: external resources ... e.g., private-practice consultants, recently-retired LHD\DCH\DEQ\MDAg experts, etc.
- Don't want one, they are expensive and we do note have extra money. I think we have informal networks of support like the forums.
- Professional organizations such as the NEHA (overall); NOWRA - sewage treatment issues; etc.
- Sharing of resources by LHD and consultation by peers should be reimbursed by MPHI or MDCH. Accreditation is a deep resource drain which is not considered anywhere in this survey or in the calculation of program cost.
- I am not sure that the cost/benefit ratio would be worth it.
- Nurse Administrators Forum.
- If it goes to MALPH or the Accreditation Commission I think it will continue to be watered down as it currently is. I almost hesitate to even check off the State agencies, since accreditation appears to be going in the direction as it was under the old system which is to be meaning less and for show.

Best Practices

BP1: The establishment of the Best Practices Directory would improve the accreditation process.
- 65 respondents (36.1%) Strongly Agree
- 85 respondents (47.2%) are Inclined to Agree
- 18 respondents (10.0%) Neither Agree nor Disagree
- 8 respondents (4.4%) are Inclined to Disagree
- 2 respondents (1.1%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

BP2: I would seek program guidance from the Best Practices Directory for the purpose of achieving accreditation.
- 72 respondents (40.0%) Strongly Agree
- 83 respondents (46.1%) are Inclined to Agree
- 13 respondents (7.2%) Neither Agree nor Disagree
- 8 respondents (4.4%) are Inclined to Disagree
- 1 respondent (0.6%) Strongly Disagrees
- 3 respondents (1.7%) did not respond to this statement

BP3: I would share resources with the Best Practices Directory.
- 74 respondents (41.1%) Strongly Agree
- 86 respondents (47.8%) are Inclined to Agree
- 14 respondents (7.8%) Neither Agree nor Disagree
- 4 respondents (2.1%) are Inclined to Disagree
- 0 respondents Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

BP4: A Best Practices Directory should be established and maintained by (check all that apply):

- 80 respondents indicated State agencies
- 54 respondents indicated MPHI
- 94 respondents indicated MALPH
- 75 respondents indicated Local Health Departments
- 58 respondents indicated Accreditation Commission
- 20 respondents indicated MI Assoc. of Public Health & Preventive Medicine Physicians (MAPPP)
- 5 respondents indicated Other (please describe below)

BP4a: Please describe 'Other' from the preceding question (open-ended comments below):

- Exit interviews needed for each program and reviewer must provide findings. A coordinator/contact person should be designated and available to the LHD and reviewers throughout the on-site evaluation.
- There are far too many questions in this survey that are making assumptions that simple answers will be misleading. For instance a peer review is meaningless if we do not approach this from a contract management viewpoint. The issue isn't peer review and improvement but formal agreement to prioritizing limited or dwindling resources. We don't need LHD peers agreeing with state agencies that we need to improve by being required to and more and more without any funding.
- Feasible if funded.
- The Best Practices Directory should include examples from all over the US and not just MI. It could be put on the state web-site for easy access.
- MALEHA
- Again, reimbursement is needed. Also it must be recognized that variations exist within health departments depending on the amount of county dollars that are available to them.
- The Directory should be established and maintained by those in charge of Accreditation. As originally conceived, Accreditation governance was equally balanced between the State and the Locals; a body reflecting that equal balance should run the process and, incidentally, the Directory. (A process in which the State calls all the shots, hires the intermediary, etc., is inherently inappropriate and coercive.)
- For EH MALEHA.
- Again I question the funding for such an endeavor.
- Private Sector.
- The Accreditation Reviewers.
- This would be an appropriate role for MPHI - more useful than the guidance that was provided in first cycle of accreditation.
- It's an interesting idea but would be perceived as too time consuming for the LHD and reviewers to maintain.
- The costs of contribution should be reimbursed as well as the costs of maintaining such a Directory.
- MEHA, UPEHA, etc
- Again a waste of money, resources and time. The tool is very specific and local health departments are already networking to achieve their goals.

Training

Train1: Additional training on the accreditation process is needed for LHDs.

- 52 respondents (28.9%) Strongly Agree
- 54 respondents (30.0%) are Inclined to Agree
- 40 respondents (22.2%) Neither Agree nor Disagree
- 27 respondents (15.0%) are Inclined to Disagree
- 5 respondents (2.8%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

Train2: Additional training on the accreditation process is needed for program reviewers.

- 92 respondents (51.1%) Strongly Agree
- 59 respondents (32.8%) are Inclined to Agree
- 19 respondents (10.6%) Neither Agree nor Disagree

- 7 respondents (3.9%) are Inclined to Disagree
- 1 respondent (0.6%) Strongly Disagrees
- 2 respondents (1.1%) did not respond to this statement

Train3: Accreditation would best be improved by additional LHD training with respect to:

- 29 respondents indicated Self-assessment
- 32 respondents indicated On-site review
- 18 respondents indicated Corrective plans of action
- 66 respondents indicated Individual programs (sections of the Tool)
- 19 respondents indicated Other (see below)
- 16 respondents did not respond this question

Train3a: Please describe 'Other' from the preceding question:

- I have no idea! I am not sure if it is needed!
- Elimination of the existing program and placement in the hands of a 3rd party nationally recognized evaluator.
- A manual for each program with specifics including recommended forms, policies, sample drawings, etc.
- All the areas listed above should be a part of the training program on accreditation for LHD.
- Many programs within the health department have yearly meetings. Those meetings provide an opportunity to explain accreditation standards and what will be expected as assurance that a standard is being met.
- All of the above.
- Applying standards consistently.
- Most of the reviewers for the programs under my division were very knowledgeable re: the programs and seemed to have been familiar with the accreditation tool. Individual interpretation of the tool did not seem to be an issue for most programs. Looking at requirements that more closely reflected what is important to evaluate in determining the how well the programs was functioning, serving the needs of the participants and meeting regulatory requirements seemed to be the problem, not knowledge but ability to comply with what at times seemed a little nitpicking and not relevant to the delivery of service. The PH programs in our agency fared very well, unlike the EH programs. Most of the PH programs had been evaluated on a regular basis by the state and were used to the process. Policies and procedures were in place and had been for a long time. Documentation expectations have long been in place. Staff were used to the program requirements and for the most part excelled in meeting them.
- Individual programs (sections of the tool).
- All of these areas.
- Additional LHD training is not required at this point in time.
- While noting a disagreement to the need for additional training, I believe that more effort is needed to better utilize self-assessments and CPAs as noted earlier in this survey.
- In general, training in all of the above areas may be needed for the LHD if the process or indicators are changed.
- Consistent standard, understanding of the different structures of metro versus rural agencies. Individual understanding of program standards and out to articulate clearly what is expected in practical ways, and suggest resources.
- On only a few rare occasions have we found that the staff had not prepared by careful review of requirements in the self-assessment, but this could be emphasized more strongly to LHDs.
- Training is needed in all of the above areas: Self-Assessments, On-Site Review, Corrective Plans of Action, Specific Program Areas; and other areas LHDs and Reviewers need.
- All would need to be trained. We should continue to be sure we're interpreting and evaluating indicators consistently.
- My note in the final text-box of this survey explains my non-answer ("I don't know") to this question.
- Obtaining funding to complete requirements of state unfunded mandates
- All of the above.
- Looking at practical ways of doing work to meet MPR's in the field. Reviewing the basics from time to time.

- If there is massive change in the way the accreditation process is conducted then I agree with the need to educate and train at all levels.
- All the above is needed.
- Program standards, Procedures of LHD, Capacity of LHD.

Train4: Accreditation could best be improved by additional program reviewer training with respect to:

- 18 respondents indicated Self-assessment
- 63 respondents indicated On-site review
- 18 respondents indicated Corrective plans of action
- 47 respondents indicated Individual programs (sections of the Tool)
- 24 respondents indicated Other (see below)
- 10 respondents did not respond to this statement

Train4a: Please describe 'Other' from the preceding question:

- An on site review!!
- See above for suggestion regarding the use of an assessor, by Section, early in the process and throughout.
- Reviewers should not have pre-conceived notions on what "they think," are corrections for the local public health department. We were cited as not having the Disease Control Division working with Environmental Health, which was incorrect. Some of the people chosen to be reviewers should not have been conducting reviews.
- Accreditation would be better served if the state agencies trained LHDs as opposed to evaluated them for contract compliance.
- Program reviewer need to be trained so that they can review a program and not become judgmental and be able to review a program to see that it is or is not meeting the spirit of the MPR.
- Ensuring that all reviewers follow same guidelines regarding the exit interviews. I was under the impression that we should not tell the LHD what indicators were missed. This information would be communicated in their report. It is frustrating to hear that other reviewers indicate which indicators are missed during their exit interviews. With our program, we often need to consult with our program manager before determining if an indicator is met or not met. We should all be consistent.
- All the areas listed above should be a part of the training program on accreditation for reviewers.
- Clear measurable standards are needed within individual programs.
- Exit interview training to establish consistent exit interviews through all programs.
- Reviewers must have an understanding of a program from both a state and local perspective. Too often they only have the state perspective, which sometimes is impossible to meet. There also needs to be clarification of their role--is it simply to see if a standard is met or is it meant to be consultative and collaborative?
- Consistency . . . in application of standards and philosophical approach.
- Applying standards consistently.
- All of these areas.
- Removing subjectivity from the evaluation.
- Consistent standards of "best practices" balanced with requirements of programs.
- All of the above. Reviewers are inconsistently trained in all regards.
- I believe that if there are two auditors for a program such as FP, then they need to coordinate their site visit. In this last review we had a team that each wanted the same information at the same time. This resulted in staff having to make duplicate copies after they were totally set up for the review. The reviewers did not work well together, and were very demanding and rude. They did not even know where each of them was staying for the night, and that was an issue. I have gone through this process twice before, so I know how smoothly things can run.
- Giving accurate, non biased, strength based feedback during review.
- Contracts, Local financial limitations, Understanding of fact that the program they are reviewing is not the entire focus of the agency.
- Program standards, Best practices.
- My note in the final text-box of this survey explains my non-answer ("I don't know") to this question.

- All of the above. Clearly two major problems exist: 1. Consistency among Reviewers from program to program and from LPH dept to LPH dept. 2. Constantly evolving MPR's which make AC a 'moving target.'
- All of the above.
- Training is needed in all of the above areas: Self-Assessments, On-Site Review, Corrective Plans of Action, Specific Program Areas; and other areas LHDs and Reviewers need.
- All of the above. Reviewers are inconsistently trained in all regards.
- See above.
- In general, training in all of the above areas may be needed for the program reviewer if the process or indicators are changed.
- Reviewers should at least read what other state agencies are requiring/reviewing. This would help promote greater sense of team and unity, as well as broader understanding of public health in the state.
- Evaluating programs from a holistic viewpoint rather than specific program; methods to increase evaluator common sense.
- See above for suggestion regarding the use of an assessor, by Section, early in the process and throughout.
- Exit interview training to establish consistent exit interviews through all programs.
- All the areas listed above should be a part of the training program on accreditation for reviewers.

Comm1: I am familiar with the membership and purview of the Accreditation Commission.

- 24 respondents (13.3%) Strongly Agree
- 54 respondents (30.0%) are Inclined to Agree
- 28 respondents (15.6%) Neither Agree nor Disagree
- 43 respondents (23.9%) are Inclined to Disagree
- 29 respondents (16.1%) Strongly Disagree
- 2 respondents (1.1%) did not respond to this statement

Comm2: There is adequate representation of local health departments on the Commission.

- 12 respondents (6.7%) Strongly Agree
- 23 respondents (12.8%) are Inclined to Agree
- 84 respondents (46.7%) Neither Agree nor Disagree
- 41 respondents (22.8%) are Inclined to Disagree
- 14 respondents (7.8%) Strongly Disagree
- 6 respondents (3.3%) did not respond to this statement

Comm3: Current communication between the commission and the accreditation process stakeholders is adequate.

- 9 respondents (5.0%) Strongly Agree
- 12 respondents (6.7%) are Inclined to Agree
- 73 respondents (40.6) either Agree nor Disagree
- 54 respondents (30.0%) is Inclined to Disagree
- 25 respondents (13.9%) Strongly Disagree
- 7 respondents (3.9%) did not respond to this statement

Comm4: The commission could improve the accreditation process by (open-ended responses below):

- Finding ways for all LHDs who want to be more actively involved and engaged in the process. Build in advisory and input producing mechanisms.
- Providing faster response about their determination of accreditation designation. Perhaps they should meet more frequently than quarterly.
- Setting up an Inquiry Process that is used when there is a formal disagreement between the LHD's and the evaluator's findings. Even after a formal written request to the Commission for an inquiry, our next contact was a letter of notification of loss of Accreditation from the Commission. My perception is that the Inquiry Process was just window dressing and nothing else.
- I didn't even know there was such a commission.

- I believe the decisions made regarding changes to the accreditation process need to follow a more formal process of approval including a grassroots review by LHDs who will be obligated to comply, a peer review with comments feedback and final approval by MALPH. There needs to be a direct relationship between LHD expenses to achieve MPRs and State Funding. If funding does not keep pace with increasing expenses the MPRs should be reduced by the above formal mechanism.
- Post the minutes of commission meetings {*on*}the various list serves that are being used by the LHD
- The Commission is a secretive, exclusive "inquisition type" body that makes decisions on local departments status without due process and behind closed doors so their is no opportunity for criticism for the body or the state agencies involved.
- Wider involvement of the LHD with the commission (both urban and rural LHD).
- Adding community representatives is suggested.
- The role of the Commission is changing and may need re-defining. AQIP has assumed responsibilities that many might think should belong to the Commission. Is the Commission a rubber stamp for the State agencies or does it have a basic oversight responsibility?
- Looking at the process to improve and enhance the public health system in Michigan, not looking at contract compliance with individual LHD's. The commission must remove itself from State or MPHI ties and become independent.
- Add the topic of Accreditation Commission to the training for LHD.
- More timely feedback to LHDs on accreditation status and corrective plans of action. Process currently takes months.
- Assuring the accreditation needs and expectations of it's reviewed customers, LHDs, are being met.
- Not sure.
- Facilitating input from all vested parties.
- Developing a step system. 95-100% = Accred. with Commendation; 90-94% = Accred.
- Having more EH directors on the board, especially smaller departments that are struggling.
- Provide funding to achieve the process.
- Reviewing each agency by the same standards over the 3 year cycle. As improvements are made they would become effective with the next accreditation cycle. The only exception would be with a standard that becomes obsolete and than it should be excluded retroactively to all agencies reviewed in the current cycle.
- Encouraging and building into the process the regular appearance of LHD's before a better-balanced Commission to comment on process and content of Accreditation, both generally and as each LHD experiences the process.
- Having an appeals process which is useable (user friendly).
- LHD representatives on the Commission should be selected by MA{*LPH*}
- There have been several instances where communications to the commission that never received a reply.
- Increasing communication and having LHD representation that is true representation and having equal team members.
- Having the commission's role and responsibility clearly defined for all participants. Opportunities to attend commission meetings would be an element in better understanding their involvement.
- Having the various disciplines represented. i.e. nursing E.H.
- Allowing LHDs to attend or at least provide input at the Commission meetings when their LHDs is being reviewed to determine accreditation status.
- It is helpful to have occasional news on where the focus is, strategic plans around accreditation, and perhaps implement peer reviews as a midpoint assist to struggling agencies.
- Allowing more local input into the tool. In particular, Family Planning and Food Service were written for local failure.
- Following their Bylaws. It would appear that the Current A. Com. is NOT assuming the responsibility assigned it in its Bylaws. They have no budget, no minutes and no teeth. All of the AC's decisions must be "processed yet again at MDCH." In my opinion, the AC has failed to execute its duties.
- What Commission?
- Sharing what they're doing and what their "purviews" are with reviewers.

- Timely, accuracy, if items are included in the review process there should be a baseline of funding. In some small departments the amount of money received for programs not adequate to meet MPRs
- Information appears to be dispersed sporadically.
- My only reservation in this area stems from a negative answer to my question as to whether I could attend a Commission meeting at which our LHD would be a subject of discussion -- I was advised that it the Commission would prefer that I not attend. That was disappointing...and suggestive of a 'communication problem' between the Commission and its stakeholders.
- Communicating to low level employees who you are and what you do.
- Don't have any idea who and what the commission is.
- Reimbursing for the costs of the process, allowing MALPH to choose LHD representatives.
- Making sure there are at least 2 field sanitarians in the commission to let this group know what it is like to run around and do all the paper work
- Not having held to a standard that is beyond their control, as in MCIR percentages.
- Informing all health departments the outcomes from the reviews. It is too easy for LHD's to hide the reason(s) they were not accredited and therefore this miss{*ing*} information promotes negativity against the accreditation process. Why are the reports not public information. What do the LHD's have to hide if there are no real problems?
- Adhere to the definition of accreditation rather than confusing accreditation with the term of site visit.

Michigan Public Health Institute

MPHI1: I understand MPHI's role in the accreditation process.
- 25 respondents (13.9%) Strongly Agree
- 66 respondents (36.7%) are Inclined to Agree
- 29 respondents (16.1%) Neither Agree nor Disagree
- 38 respondents (19.4%) are Inclined to Disagree
- 17 respondents (9.4%) Strongly Disagree
- 5 respondents (2.8%) did not respond to this statement

MPHI2: The coordination of the Accreditation program is enhanced by MPHI's participation.
- 19 respondents (10.6%) Strongly Agree
- 30 respondents (16.7%) are Inclined to Agree
- 76 respondents (42.2%) Neither Agree nor Disagree
- 25 respondents (13.9%) are Inclined to Disagree
- 20 respondents (11.1%) Strongly Disagree
- 10 respondents (5.6%) did not respond to this statement

MPHI3: Processes for which MPHI is responsible are handled in a satisfactory manner.
- 18 respondents (10.0%) Strongly Agree
- 27 respondents (15.0%) are Inclined to Agree
- 84 respondents (46.7%) Neither Agree nor Disagree
- 23 respondents (12.8%) are Inclined to Disagree
- 17 respondents (9.4%) Strongly Disagree
- 11 respondents (6.1%) did not respond to this statement.

MPHI4: MPHI could improve coordination of the accreditation process by (open-ended responses below):
- Returning to a more involved and engaged process. Be on-site for reviews. Present at LHD conferences.
- Providing more opportunities for interaction between reviewers and LHDs throughout the accreditation cycle, not just during the onsite review.
- They should not be involved. It should be LHD and the state agencies only!
- Contracting it out to a 3rd party nationally recognized evaluator.
- I do not know the role of MPHI in the accreditation process so I can not make a recommendation for improvement.
- More clearly define their role.

- Revamping the all reviewer meetings. The majority of the information presented in these meetings is repetitious for reviewers. They should hold separate meetings for new reviewers. In addition, problems with specific reviewers should be addressed individually and not during the all reviewer meeting.
- MPHI should be removed from the process. They only add another layer of confusion and delay in the process. They do not add any value to the system.
- Improve communication with reviewers.
- Communicate to LHD the role of MPHI.
- Assure on-site reviewers have access to all information provided in advance by LHD prior to doing site visit.
- They have done a fine job.
- MPHI adds another layer to the bureaucracy/process without an added value. MPHI does not have an understanding of the role and functions of health departments.
- Stepping back and letting an agency with credentials in accreditation do the job.
- COMMUNICATION, COMMUNICATION, COMMUNICATION.
- Better communication. Also, state programs need to be held to the same standard as the LHD. Guidelines must be specific and written!
- Better preparation for the reviewer's meeting. Clearer coordination with the MPHI on site reviewer.
- Attendance at on-site reviews
- Would like to see it coordinated by MDCH.
- Describing what they do.
- MPHI staff's role in accreditation needs to be clearly defined. In addition, if they are expected to provide support and guidance for LHD, then the staff needs to be accessible to answering the LHDs questions and concerns.
- MPHI and the reviewers do not seem to communicate very effectively; particularly when the final details are needed for what reviewers will be on-site and which day they will arrive.
- My experience was that MPHI was not responsive in a timely manner to questions and did not make the latest versions of the tool available. This may not have been their fault but, when you are using a 2000 tool for a 2001 review and are expected to be in compliance for the 3 preceding years on items that changed, you are poised for failure.
- Providing adequate leadership and management of the process. MPHI is the appropriate location for the coordination, but the assigned staffing could be improved. Also, MDCH needs to provide strong in-house coordination leadership for the process to be successful.
- Adding additional muscle to the Accreditation Commission's operation and Staff Support. For instance: The Accreditation Commission should be (and , in fact is charged with) doing what the ad hoc AQIP Committee is currently doing !!!
- When we were accredited, a person drove 4 hours for 30 minutes to introduce the process. Why??
- Providing more time to develop revisions for each year's new standards and tool.
- Accurate and Timely.
- (1) Coordination can be streamlined by eliminating necessity for back & forth communication from Programs to MPHI to LHD and vice versa (see earlier suggestions re: use of Website. (2) Program Reviewers need be able to spell-check and review their own documentation. (3) A standard database should be developed for recording and reporting findings, utilize “Best Practices” from each program area for suggestions, i.e. some programs have developed databases that can be adapted to any program.
- MPHI should not be part of the accreditation process.
- Greater availability of staff.
- My note in the final text-box of this survey explains my non-answer ("I don't know") to this question.
- RETURN THE PROCESS TO MDCH.
- Educating lower level employees who you are and what you do.
- Don't know the role or responsibilities of MPHI.
- First, what do they do? When I tried to find out I got the run around.
- Stronger system to log in and distribute materials coming from LHDs.
- More truthfully representing the history of Michigan's Accreditation process in its publications.
- Having more direct authority and not so many other agencies involved.

National Performance Standards for Local Public Health (NPHPS)

NPHPS1: I am familiar with the CDC National Public Health Performance Standards.

- 23 respondents (12.8%) Strongly Agree
- 58 respondents (32.2%) are Inclined to Agree
- 29 respondents (16.1%) Neither Agree nor Disagree
- 35 respondents (19.4%) are Inclined to Disagree
- 23 respondents (12.8%) Strongly Disagree
- 12 respondents (6.7%) did not respond to this statement

NPHPS2: Accreditation with Commendation for LHDs should be tied to the use of the NPHPS.

- 13 respondents (7.2%) Strongly Agree
- 51 respondents (28.3%) are Inclined to Agree
- 82 respondents (45.6%) Neither Agree nor Disagree
- 15 respondents (8.3%) are Inclined to Disagree
- 7 respondents (3.9%) Strongly Disagree
- 12 respondents (6.7%) did not respond to this statement

NPHPS3: The NPHPS for local public health departments should be incorporated into the accreditation program in a subsequent cycle.

- 13 respondents (7.2%) Strongly Agree
- 50 respondents (27.8%) are Inclined to Agree
- 84 respondents (46.7%) Neither Agree nor Disagree
- 12 respondents (6.7%) are Inclined to Disagree
- 7 respondents (3.9%) Strongly Disagree
- 14 respondents (7.8%) did not respond to this statement

Medical Direction

MD1: I am familiar with the indicators that address medical directors.

- 43 respondents (23.9%) Strongly Agree
- 47 respondents (26.1%) are Inclined to Agree
- 25 respondents (13.9%) Neither Agree nor Disagree
- 27 respondent (13.9%) is Inclined to Disagree
- 24 respondents (13.3%) Strongly Disagree
- 14 respondents (7.8%) did not respond to this statement

MD2: The indicators in the Administration Section of the Accreditation Tool (specifically G1.1-G1.4) are sufficient to address medical director competencies.

- 16 respondents (8.9%) Strongly Agree
- 40 respondents (22.2%) are Inclined to Agree
- 84 respondents (46.7%) Neither Agree nor Disagree
- 19 respondents (10.6%) are Inclined to Disagree
- 6 respondents (3.3%) Strongly Disagree
- 15 respondents (8.3%) did not respond to this statement

MD3: Strengthening the existing measures of medical director competencies would improve local public health by (open-ended responses below):

- Helping us understand what core competencies a medical director should have.
- Medical Director requirements need to consider reality. State can't decide what they want the position to do. Focus on job to be done, not hours and number of people in jurisdiction, or number of LHDs working with.
- Ensuring that they not only meet staffing qualifications, but that they are also actively engaged in their LHDs activities.
- This section should not be included in this questionnaire. It is a reference to specific MPR's. Why include this and not other specific MPR requirements or specific program requirements?
- I had no idea that there was a medical director portion????

- Add roles, responsibilities and performance standards to indicators.
- Assurance that all medical directors had adequate backgrounds in all program areas of LHD in order to act as an expert resource.
- Measures are sufficient
- No comment
- Requiring them to pay attention to EH programs and give them the respect like they give nurses.
- Enforcing the indicators for the medical director competencies, especially continuing education in public health.
- Assuring medical directors are properly trained and keep up-to-date on public issues.
- Bay County's current Medical Director has been in thee position for 8 years and is fully committed and dedicated to the position. However, because he is not "qualified" a new Medical Director needs to be appointed for the next accreditation survey. A grandfather clause should be available to current Medical Directors can continue to serve. Once the "unqualified" Medical Director leaves employment, a "qualified" person would have to be appointed.
- Framing the breadth and depth of medical director's role and function + assuring proper formal relationships exist between medical directors and non-physician health officers.
- I'm not sure it is realistic for all areas of Michigan. I also think the same rules should apply to all Medical Directors and not just "new" ones.
- In regards to the preceding NPHPS and Medical Direction categories…my answers reflect the absence of any knowledge of these aspects.
- Determining knowledge base in public health, not just degreed.
- In an effort to assess the medical director's competencies as they relate to public health trainings, they should not only provide documentation of their CMEs, but also in all trainings that are related to the dept. In addition, the medical director should provide a minimum number of in-service hours to train personal health staff on current health issues and/or topics.
- Providing a stronger focus on community health, develop a strong relationship with the local medical community, provide the medical emphasis to the administrative structure.
- Providing more consistent standards and expectations of involvement. Providing substantive expectations of training and knowledge of best practice in public health.
- No small group of indicators can measure the effectiveness of a medical director. The overall outcome is the best indicator.
- 1. Establishing standards which would include everything from Board Attendance to inservicing to mandatory participation in State organizations as well as CME requirements.
  2. Increasing input from the perspective of the Physician concerning program administration and the establishment of new programs (community needs).
  3. Assigning discipline appropriate responsibilities at the LPH level consistent with Physician licensure and qualification. (See Public Health Code...)
  4. Weeding out those Medical Directors who are currently "retired on the job" or disinterested....and allowed to be so by Health Officers... etc.
- Assuring that the medical directors, through their attendant activities are actively involved in the generation, maintenance and development of appropriate health policy and practice for their respective jurisdictions.
- I am not sure why this question is here, if we are not going to address the competencies for all public health leadership disciplines.
- Suggest continuing education/professional membership.
- Medical Directors are not the sole component of local public health. Many other disciplines contribute; physicians are just one spoke.
- My note in the final text-box of this survey explains my non-answer ("I don't know") to this question.
- It's not so much competency but the fact that the agency director should not be a doctor
- Do not know what the measures are
- Defining what roles the medical director can and should be doing.
- Ensuring that MDs have a consistent understanding of the role of public health. Not all of them understand population based medicine.
- Taking them out of the loop. Typically they don't seem to have a clue about EH.
- I believe that they should be mandated to be in the review process when G1.1-G1.4 are being addressed.

Demographics

Demog1: If you represent a LHD, what is your accreditation status?

- 15 respondents have Provisional Accreditation
- 95 respondents are Accredited with Commendation
- 24 respondents are Accredited
- 16 respondents are Not Accredited
- 30 respondents provided No response

Demog2: If you represent a LHD, has you health department completed Cycle 2?

- 50 respondents indicated 'Yes'
- 107 respondents indicated 'No'

Demog3: What is your primary area of job responsibility?

- 32 respondents (17.8%) indicated Health Officer
- 5 respondents (2.8%) indicated Medical Director
- 34 respondents (18.9%) indicated Administrator
- 27 respondents (15.0%) indicated Environmental Health
- 24 respondents (13.3%) indicated Personal Health Services
- 5 respondents (2.8%) indicated Health Education
- 6 respondents (3.3%) indicated Accreditation Reviewer
- 23 respondents (12.8%) indicated Other (see below)
- 24 respondents (13.3%) provided No response

Demog3a: Please describe 'Other' from the preceding question (open-ended responses below):

- MDCH Manager for STD Program.
- Home Care Director- involved with the public health and CHAP accreditation and agency policy development
- Management of assessment regarding Sections A and B.
- Both Health Officer and Environmental Health Director
- Director of the Disease Control Division
- I am with MDA not LHD
- State Program Manager
- Reviewer
- Quality Management Consultant
- Laboratory Division Director
- Health Officer and Medical Director
- Deputy Health Officer
- Finance
- Agency (Administrative) Support
- Planner/evaluator
- Division Director
- Health Promotion and Bioterrorism
- Staff Development
- Planning, organizing and budgeting of programmatic, as well systematic responses to coordinated local public health jurisdictional service delivery problems
- Deputy Health Officer
- I am an Accreditation Reviewer and a Coordinator and trainer for my program area.
- Planner
- Community Health Assessment, plus Manager of Edication and Substance Abuse Prevention, plus Emergency Preparedness Coordinator
- IT
- Program Coordinator
- Health planning

Free-Response: Please include any additional ideas for accreditation process improvements:

- Not sure about the demographic questions. Can't answer number one or two as they only apply to LHD's and you can't opt for "no answer".

- Thanks for all of your hard work on this.
- I believe the exit interview should be used extensively to discuss the findings and resolve differences of opinion at that time. This could alleviate disputes in the future.
- Instead of spending hundreds of thousands of dollars for all of the health departments doing their own plans, why not have a set of standards that meet the national standards and where local health departments could demonstrate that they have the materials in place. There may be differences in methods between health departments, but those could be cited by the local agency. State funding should be made available for this tedious process. In addition, many local public health people feel that the Michigan Department of Community Health should undergo the same process of accreditation. The accreditation process needs to be cycled every 5 years with periods of the process to be placed on hold when major situations are occurring in the state such as smallpox vaccination efforts, West Nile Virus, SARS and now monkey pox outbreaks. Many of us worked countless months on the accreditation process while attempting to provide our routine services.
- Accreditation has become a tool for State Government to pressure local health departments into complying with an ivory tower philosophy of what local public health services should be and a method for contract compliance where there is no clear negotiating format or formal acceptance by locals to the contract.
- The MPRs need to reflect the way public health programs are run rather that changing the programs to meet the MPRs. Local public health programs were established to meet the need of the public. But the MPRs were set up to meet the needs of an accreditation process.
- As a recent hire, I do not have a lot of experience with the process except an overall negative experience related to an overall lack of professionalism by certain accrediting agencies.
- My answers are often based on current improvement activities that my agency is involved in.
- Accreditation must be continuous & we need to find ways to embrace this rather than an activity that consumes LHDs and the reviewers every 3 years. I think the focus must be core functions and not all the details that have been established in WIC, FP, etc. I'd rather see $$$ dedicated to determining if these details are improving MCH services and outcomes, however, I understand that we need to meet Federal requirements.
- 1. Need to establish a STATE/LOCAL committee for each program area planned to be reviewed through the accreditation process. This system should be modeled after the recent process being completed by Dept of Ag for the Food Sanitation Program. Local representation from throughout the state met with state program personnel to define what is expected for each MPR. Prior to the initiation of the accreditation process each program area should be similarly reviewed and adequate time to have locals understand what is expected and become prepared for the next round of accreditation.
  2. Suggest a review cycle of every 4-5 years with a one year break in between to review the previous process, convene state/local program committees, refine the process, etc., before commencing with another round.
  3. More program and area specific training detailing the MPR's and what is expected to meet an MPR.
  4. Remove MPHI from the process. They add another layer that causes confusion, delays, miscommunication, etc. Should deal directly with State program personnel.
- 1. On exit interviews, all points/citations should be brought up not just written in the report later.
  2. CDC/National standards should not be added to MPR's but either incorporate those that overlap or just use the National standards.
  3. Reviewers idea to meet the criteria is sometimes their idea of what should be done, they are too often not flexible to accept other ways of doing things. Additionally some of their expectations for recommendations are to accommodate reviewers and have no or little enhancement in the service.
  4. If reviewer are observing and reviewing a professional the reviewer should have credentials that meet the program requirements to provide the service.
  5. Are recommendations required to do or are they suggestions for further improvement?
  6. On-site review is very lengthy, interruptive, and involved. JACHO is directed more administratively and process and less on following staff around or looking at refrigerators.
- One of the reviewers that came on site was quite rude and degrading to staff. She did not leave a good impression of the accreditation process.

- No need for State to seek outside money for outside evaluation of accreditation process, just continue to get customer feedback, as you are doing with this survey.
- Assure that on-site reviewers of programs (e.g. Family Planning) are consistent in their review and do not review LHD programs based on their bias for a current or former employer (e.g. Planned Parenthood staff delivering significant criticism because the LHD program does not look exactly like the PP standards and guidelines of their agency/clinic.) Assure that on-site reviewers treat LHD staff with respect and not approach the review as an "expected" failure.
- Have the guidance document more fully represent the LHD programs and services.
- Accreditation process for LHDs should include a community input component. We provide services at the local community level. A questionnaire specifically designed to elicit input from governing boards, key stakeholders, other community partners, and served clients should be considered. Do they think we are doing our job?
- Another category should be added to accreditation. Consideration should be given to those Departments who have made a serious effort and have shown improvement in their programs from their previous evaluation. If the local health department disagrees with the reviewer's evaluation, they should have an opportunity to take issue with the reviewer's supervisor.
- Asking for field sanitarians input might help and have the state fund each department with consistency. It ain't happening!!!!! If the state does not have the money to see to it that we meet these standards then they should be suspended until the state can.
- I think an accreditation process every 3 years is unnecessary. I think every 5 years is adequate.
- Personal Health and Administrative and "general" areas were my responsibilities. We did great. When there was a problem in the food section, the HD was reviewed as "all or nothing". Everyone knew there was a serious problem with the reviewer.
- A survey of this type would benefit from having a comment option for each section of questions (i.e., self assessment, on site review, etc.) A better answer option than "neither agree nor disagree".
- Any future accreditation quality improvement surveys need to include a comment section for each category.
- Primarily the indicators and the interpretation of them are understood by all. Also, that adaptations in planning for visits, are communicated to all that need to know.
- I believe that the accreditation review schedule should be more flexible and that one year of no accreditation review would allow LHD to recover financially and emotionally from the review. There were many policies that were required to have in round one that were not even looked at. There were a lot of personnel credential requirements that were not even looked at. Also, those reviewers must be human beings with personalities, feelings, be flexible and must be reasonable. One last thought - if accreditation were eliminated, LHD would have the resources to focus on problematic programs.
- Overall, the accreditation process can be substantially improved by providing enhanced training to state reviewers on how to conduct evaluations. In addition, LHD can benefit from trainings on how to prepare for accreditation.
- Perhaps, after weighing the outcomes of accreditation reviews, trainings, workshops, or other improvement tools on-line could be developed for the LHD to access for practice improvement.
- The entire process drags on for too long, and this is due to having to meet the exact requirements for all 800+ items (indicators & bullets). It would be helpful to establish which indicators (or bullets) are "critical" and must be met exactly to specifications, and which are less critical and can be cited with "recommendations" that should be met by next review or in order to receive commendation. Currently there are only a few "important" indicators which will hold up a LHD's being awarded accreditation. I believe that significantly more (maybe half) could fall in this category. Successfully completing all critical indicators could earn the "accredited" title, and commendation could be added later upon compliance with a certain percentage of the "important" indicators.
- While I have been critical with some of my comments, I believe accreditation is a good tool to improve health department quality of service. This was the first effort and there now is a chance to improve the process. This process should be educational not punitive. Some of the reviewers were adversarial and others seemed to lack an understanding of the section they were evaluating. Consistency was also lacking as certain LHD's received a "break" by some evaluators.

  I believe that the number of essential indicators should be trimmed back by about 20%. Some

really are not "essential". Instead they should be "importants" and one could receive accreditation by meeting 95% of the essentials (with corrective action on the other 5% of course). Accreditation with commendation would be reserved for those meeting all essentials and 80 or 90%? of the importants. If MPHI is to be involved, an increased commitment is needed to assure that this effort is worthwhile. There is a lot of work that has to be done by locals to prepare, unfunded work at that.

- Need a standard "model" for all funded programs in the process to assure the consistency of MPRs, indicators, evaluation criteria, training, implications for not-mets, etc. Also need to assure high caliber staffing to coordinate and manage the process at MPHI and State Agencies. Finally, there needs to be an assurance component that State Agencies have the resources to support compliance for all MPRs/indicators being required of LHDs (i.e., are programs adequately funded for expectations and are State Agencies sufficiently staffed to fulfill all of their program management responsibilities to support the local programs?) - Just comply with Parts 22-24 of the Michigan Public Health Code for State and Local responsibilities for public health programs.
- "Medical Direction" should be a 'stand alone' section in the Accreditation tool...AQIP should recommend that MAPPP, MALPH and MDCH meet to develop that section. The Reviewer for the section on "Medical Direction" should and must be a Physician with LPH experience.
- Too much process involved in accreditation. Program evaluation and cerifications were more useful. There's too much paper work to this whole process!
- As far as our programs are concerned, the process has worked very well, especially after the first year of accreditation.
- Questions related to NPHPS--health departments are not funded at level to include these standards in the review process. Michigan needs to look at this but then tie funding to the performance standards.
  Changes to the accreditation process should only be done at the end of each cycle--not annually. We are not fairly comparing Health Departments when the process in changed annually.
- ASPN is a great idea--but who covers the cost {*to*}LPHs?
- Many programs are not adequately funded to cover MPRs, i.e., HIV. There needs to be a baseline for funding for each program included in accreditation.
- Funding formulas need to be reviewed for equity, i.e., sewage and water when MPRs are in place for programs to meet.
- 1) The on-site process can be improved by:
  Properly educating the LHD staff on the accreditation process;
  LHD's correct their insufficiencies during their self- assessment prior to the on-site review and therefore it may not be something put into the CPA;
  The LHD's need to understand that the reviewer must be objective and is not there to penalize them;
  On-site reviewers must be consistent with recommendations.
  2) Consider ranges of meeting standards/indicators. Consider measurements that show growth over time, consider point ranges for accred with commendation, accred, not accred. Need clearer examples of what constitutes "special recognition".
  3) Create a format for exit interview dialogue.
  4) Accred. could be focused on national public health guidelines rather than funded services (HP 2010).
  5) The accred. tool is also used as a training tool for new employees working in our section.
  6) Possibly create training by section as well as the annual meeting with all sections.
- Just a clarification for your information: As a new AHO in July, 2001, I did not participate in this LHD's Accreditation process ... except that, on my first day on the job, I was informed that our LHD would not be accredited! Therefore, my responses should be considered with that [non-] history in mind. My experience with this LHD accreditation process is all 'post-evaluation' ... however, in a previous life, I've participated in two JCAHO Accreditation Reviews ... so some of my answers reflect those experiences.
- It is difficult to reach MPRs for unfunded programs (ie: CHA, Health Promotion, etc) and under-funded programs
- We do not have an Accreditation Process. We have a Contract Compliance Process. A true Accreditation Process would deal with LHD CAPACITIES and be conducted by a Local Public Health Peer such as NACCHO and not a funding body.

- Accreditation should be based on available local resources. For those items that don't meet state standards, then the state should do the program. Don't tie all programs in together for funding (where you have to meet all mandates for all programs). Locals should have the option of opting out of a specific program and lose state funding for that program only.
- Many of the areas on this survey could be answered with qualifiers. It would be more informative to explain or provide narrative to some of the responses.
- WIC should not be in the accreditation process because of the two year cycle. Remove MCIR county percentages from a measure, maybe just agency percentages. The achievement of the measures should not be 100% compliance. Maybe consider 100% compliance of required or essential measures, then a certain percent of other measures.
- Funding must be provided to LHD to continue or expand accreditation. It would be counter-productive to be accredited and have to cut services and lay off staff due to the expense of accreditation.
- Two auditors that are evaluating the same program need better communication between each other.