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Section I: Powers and Duties

MPR 1

A local health department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and health services delivery systems; and regulation of health care facilities and health services delivery systems to the extent provided by law.

Reference: *P.A. 368 of 1978, Section 2433*

Indicator 1.1

A local health department shall implement and enforce laws for which responsibility is vested in the local health department. (Section 2433 (2) (a))

This indicator may be met by:

- Lists of state and local laws and regulations for which the local health department is responsible in preventing disease, prolonging life, and promoting public health (see Attachment A for state laws that may be applicable).
- Documents setting out the local health department's policies and procedures for enforcement of those laws and regulations for which it is responsible.

Documentation Required:

Documents setting out the policies and procedures for enforcement, including warning orders and notices, engagement of the court to enforce orders in cases of noncompliance, and the issuance of emergency orders to the mass populace, which may include involuntary detention and treatment.

Evaluation Question:

None

Indicator 1.2

A local health department shall utilize vital and health statistics and provide for epidemiological and other research studies for the purpose of protecting the public health. (Section 2433 (2) (b))

This indicator may be met by:

- Demonstrating access to vital and health statistics.

For technical assistance, please contact Konrad Edwards at 517-335-8124 or edwardsek@michigan.gov

- Documents that demonstrate analysis and interpretation of vital and health statistics in reports for, at a minimum, the major causes of morbidity, mortality and environmental health hazards within the jurisdiction.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.3

A local health department shall make investigations and inquiries as to the causes of disease and especially epidemics, the causes of morbidity and mortality, and the causes, prevention, and control of environmental health hazards, nuisances, and sources of illness. (Section 2433 (2) (c)).

This indicator may be met by:

- A written description of the organizational arrangements and capacity to conduct such investigations, including policies and procedures for doing same.
- Documentation of required reports to the State of Michigan related to disease outbreaks and environmental health hazards.
- Documents which demonstrate the investigation of causes of morbidity and mortality and the causes, prevention, and control of environmental health hazards, nuisances, and sources of illness within the jurisdiction.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.4

A local health department shall plan, implement, and evaluate health education through the provision of expert technical assistance, or financial support, or both. (Section 2433 (2) (d)).

This indicator may be met by:

Documentation which demonstrates involvement in activities to educate the population about the major causes of morbidity, mortality, and environmental health hazards.

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Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.5

A local health department shall provide or demonstrate the provision of required services as set forth in Section 2473(2). (Section 2433 (2) (e)). See Attachment B for required services. Note: A LHD may indicate that it is not providing one or more required services. See Attachment C for excerpt from the Public Health Code (P.A. 368, Sept. 30, 1978).

This indicator may be met by:

Documentation that required services set forth in Attachment B are available in the jurisdiction either by direct delivery or through other community providers.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.6

A local health department shall have powers necessary or appropriate to perform the duties and exercise the powers given by law to the local health officer and which are not otherwise prohibited by law. (Section 2433 (2) (f)).

This indicator may be met by:

A Plan of Organization adopted by the local governing entity and approved by the Director of the Michigan Department of Community Health.

Documentation Required:

See above.

Section I: Powers and Duties

Evaluation Question:

None

Indicator 1.7

A local health department shall plan, implement, and evaluate nutrition services by provision of expert technical assistance or financial support, or both. (Section 2433 (2) (g)).

This indicator may be met by:

Documentation, which demonstrates involvement in activities to provide and/or support Nutrition Services in the jurisdiction.

Documentation Required:

See above.

Evaluation Question:

None

Section I: Powers and Duties

Attachment A

MATRIX OF SERVICES OF LOCAL PUBLIC HEALTH

Services	Rule or Statutory Citation	Required =	Basic +	Mandated +	LPHO	Allowable	Notes
		1	1.A.	1.B.	1.C.	2	
Immunizations	PA 349 of 2004 – Sec. 218 and 904; MCL 333.9203, R325.176	X	X	X	X		
Infectious/Communicable Disease Control	MCL 333.2433; Parts 51 and 52; PA 349 of 2004 – Sec. 218 and 904; R325.171 et seq.	X	X	X	X		
STD Control	PA 349 of 2004 -- Sec. 218 and 904; R325.177	X	X	X	X		
TB Control	PA 349 of 2004 – Sec. 218	X	X	X			
Emergency Management – Community Health Annex	PA 349 of 2004 – Sec. 218 MCL 30.410	X	X	X			Basic Service under Appropriations Act and Mandated Service, if required, under Emergency Management Act.
Prenatal Care	PA 349 of 2004 – Sec. 218	X	X				
Family planning services for indigent women	MCL 333.9131; R325.151 et seq.	X		X			
Health Education	MCL 333.2433	X		X			
Nutrition Services	MCL 333.2433	X		X			
HIV/AIDS Services; reporting, counseling and partner notification	MCL 333.5114a; MCL 333.5923; MCL 333.5114	X		X			
Care of individuals with serious Communicable disease or infection	MCL 333.5117; Part 53; R325.177	X		X			(4) Financial liability for care rendered under this section shall be determined in accordance with part 53.
Hearing and Vision Screening	MCL 333.9301; PA 349 of 2004 – Sec. 904; R325.3271 et seq.; R325.13091 et seq.	X		X	X		
Public Swimming Pool Inspections	MCL 333.12524; R325.2111 et seq.	X		X			Required, if "designated"
Campground Inspection	MCL 333.12510; R325.1551 et seq.	X		X			Required, if "designated"
Public/Private On-Site Wastewater	MCL 333.12751 to MCL 333.12757 et. seq., R323.2210 and R323.2211	X		X	X		Alternative waste treatment systems regulated by local public health.

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Food Protection	PA 92 of 2000 MCL 289.3105; PA 349 of 2004 – Sec. 904	X		X	X		
Pregnancy test related to informed consent to abortion	MCL 333.17015(18)	X		X			
Public/Private Water Supply	MCL 333.1270 to MCL 333.12715; R325.1601 et. seq.; MCL 325.1001 to MCL 325.1023; R325.10101 et. seq.	X			X		
Allowable Services						X	This category would include all permissive responsibilities in statute or rule that happen to be eligible for cost reimbursement.
Other Responsibilities as delegated and agreed-to	MCL333.2235(1)					X	This category is NOT connected to express responsibilities within statute, but refers entirely to pure delegation by the department as allowed. In addition to general provision, the Code allows delegations for specified functions.

Section I: Powers and Duties

MATRIX DEFINITIONS

Name	Citation	Description
1. Required Service	MCL 333.2321(2); MCL 333.2408; R325.13053	Means: (A) a basic service designated for delivery through Local Public Health Department (LPH), (B) local health service specifically required pursuant to Part 24 or specifically required elsewhere in state law, or (C) services designated under LPHO.
1.A. Basic Service	MCL 333.2311; MCL 333.2321	A service identified under Part 23 that is funded by appropriations to MDCH or that is made available through other arrangements approved by the legislature. Defined by the current Appropriations Act and could change annually. For FY 2005: immunizations, communicable disease control, STD control, TB control, prevention of gonorrhea eye infection in newborns, screening newborns for 8 conditions, community health annex of the MEMP, and prenatal care.
1.B. Mandated Service	MCL 333.2408	The portion of required services that are not basic services, but are "required pursuant to this part [24] or specifically required elsewhere in state law."
1.C. LPHO	PA 349 of 2004 – Sec. 904	Funds appropriated in part 1 of the MDCH Appropriations Act that are to be prospectively allocated to LPH to support immunizations, infectious disease control, STD control and prevention, hearing screening, vision services, food protection, public water supply, private groundwater supply, and on-site sewage management.
2. Allowable Services	MCL 333.2403; R325.13053	"Means a health service delivered [by LPH] which is not a required service but which the department determines is eligible for cost reimbursement".
PA 349 of 2004		Fiscal year 2005 Appropriations Act for the Department of Community Health.

Attachment B

LAWS APPLICABLE TO LOCAL PUBLIC HEALTH (LPH)

Public Health Code (PA 368 of 1978)
MCL § 333.1105 – Definition of Local Public Health Department
MCL § 333.1111 – Protection of the health, safety, and welfare
Part 22 (MCL §§ 333.2201 *et seq.*) – State Department
Part 23 (MCL §§ 333.2301 *et seq.*) – Basic Health Services
Part 24 (MCL §§ 333.2401 *et seq.*) – Local Health Departments
Part 51 (MCL §§ 333.5101 *et seq.*) – Prevention and Control of Diseases and Disabilities
Part 52 (MCL §§ 333.5201 *et seq.*) – Hazardous Communicable Diseases
Part 53 (MCL §§ 333.5301 *et seq.*) – Expense of Care
MCL § 333.5923 – HIV Testing and Counseling Costs
MCL § 333.9131 – Family Planning
Part 92 (MCL §§ 333.9201 *et seq.*) – Immunization
Part 93 (MCL §§ 333.9301 *et seq.*) – Hearing and Vision
MCL § 333.11101 – Prohibited Donation or Sale of Blood Products
MCL § 333.12425 – Agricultural Labor Camps
Part 125 (MCL §§ 333.12501 *et seq.*) – Campgrounds, etc.
Part 127 (MCL §§ 333.12701 *et seq.*) – Water Supply and Sewer Systems
Part 138 (MCL §§ 333.13801 *et seq.*) – Medical Waste
(Required to investigate if complaint made and transmit report to MDCH – 13823 and 13825)
MCL § 333.17015 – Informed Consent

Appropriations (Current: PA 349 of 2004)
Sec. 218 – Basic Services
Sec. 904 - LPHO

Michigan Attorney General Opinions

OAG, 1987-1988, No 6415 – Legislative authority to determine appropriations for local health services
OAG, 1987-1988, No 6501 – Reimbursement of local department for required and allowable services

Food Law of 2000 (PA 92 of 2000)
MCL §§ 289.1101 *et seq.*
Specifically:
MCL § 289.1109 – Definition of local health department
MCL § 289.3105 – Enforcement, Delegation to local health department

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Natural Resources and Environmental Protection Act (PA 451 of 1994)
Part 31- Water Resources Protection
Specifically: MCL §§ 324.3103 powers and duties and 324.3106 (establishment of pollution standards)
Part 22 - Groundwater Quality rules (on-site wastewater treatment)
Part 117 - Septage Waste Services
Specifically: MCL §§ 324.11701 - 324.11720

Land Division Act (PA 288 of 1967)
MCL § 560.105(g) - Preliminary Plat Approvals
MCL § 560.109a - Parcels less than 1 acre
MCL § 560.118 - Health Department Approval

Condominium Act (PA 59 of 1978 as amended)
MCL § 559.171a - Approval of Condominiums not served by public sewer and water

Safe Drinking Water Act (PA 399 of 1976 as amended)
MCL § 325.1016 - Public Water Supplies
Agreements with Local health departments to administer

This document may serve as a survey of appropriate laws, but may not be considered exhaustive or as a limit to responsibilities required by law.

Section I: Powers and Duties

Attachment C

Public Health Code (P.A. 368 of 1978):

333.2475 Reimbursement for costs of services; equitable distribution; schedule; local expenditure in excess of prior appropriation.

Sec. 2475.

(1) The department shall reimburse local governing entities for the reasonable and allowable costs of required and allowable health services delivered by the local governing entity as provided by this section. Subject to the availability of funds actually appropriated, reimbursements shall be made in a manner to provide equitable distribution among the local governing entities and pursuant to the following schedule beginning in the second state fiscal year beginning on or after the effective date of this part:

(a) First year, 20%.
(b) Second year, 30%.
(c) Third year, 40%.
(d) Fourth year and thereafter, 50%.

(2) Until the 50% level is reached, a local governing entity is not required to provide for required services if the local expenditure necessary to provide the services is greater than those funds appropriated and expended in the full state fiscal year immediately before the effective date of this part.

Section I-QI: Powers and Duties - Quality Improvement Supplement

MPR 1

Establish a culture of quality improvement (QI)[1] within the local health department.

Indicator 1.1

Engage local governing entity (LGE) in establishing organizational policies and direction for implementing QI.

This indicator may be met by:

Agency engagement with LGE to establish QI policies and direction for implementation.

Documentation Required:

LGE meeting agenda and minutes discussing establishment of QI policies and direction for implementation within agency.

Evaluation Questions:

- How does your agency engage the LGE regarding the establishment of organizational QI polices and direction?
- How do you keep QI visible and ongoing?

Indicator 1.2

Assure staff involvement in agency's QI activities.

This indicator may be met by:

- Agency QI policy and plan is disseminated and shared with employees.
- Operationalize a QI policy and plan.
- Employee input is sought to identify opportunities for improvement within processes and/or programs.

[1] *Quality improvement* in public health "is the use of a deliberate and defined improvement process, such as Plan-Do-Check [Study]-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community."
Robert Wood Johnson Foundation. September 23, 2009. Frequently Asked Questions about Accreditation. Accreditation Coalition Workgroup, Bialek R, Beitsch LM, Cofsky A, Corso L, Moran JW, Riley W, and Russo, P. *"Quality Improvement in Public Health"*. Submitted to the Accreditation Coalition for consideration on June 18, 2009. Available at http://www.rwjf.org/publichealth/product.jsp?id=48851

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Section I-QI: Powers and Duties - Quality Improvement Supplement

Documentation Required:

- QI policy and plan available to employees (Examples may include a hardcopy, shared agency intranet drive or employee handbook).
- Copies of ongoing communication to employees indicating leadership commitment to QI.
- Documentation of updates on QI activities at staff meetings (meeting minutes).
- Copy of employee survey and results of input received.
- Evidence of employee involvement in QI process and/or program activities. (An example includes process improvement teams).

Evaluation Questions:

- How do employees learn about your agency's QI policy and plan?
- How are employees included in QI activities?
- How are employees involved when operationalizing the QI plan?

Indicator 1.3

Systematic assessment of customer/client satisfaction with agency services and improvements made.

This indicator may be met by:

- A process to assess customer satisfaction.
- Customer satisfaction results and analysis.
- Process and/or program improvement based on customer assessment.

Documentation Required:

- Description of process and tool used for collecting feedback and evaluating results.
- Example(s) of results in collecting and analyzing customer satisfaction data.
- Example of how customer satisfaction results were used for process and/or program improvement.

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Evaluation Questions:

Describe the agency's process to collect customer feedback.

- What types of customers do you survey?
- How does your agency analyze customer satisfaction data?
- How is the feedback shared with staff?
- How does your agency use customer satisfaction data for process and/or program improvement?

Section I-QI: Powers and Duties - Quality Improvement Supplement

MPR 2

Evaluate the effectiveness of public health processes and/or program goals and performance measures.

Reference: *Essential Public Health Service #9*

Indicator 2.1

Assure process is in place for the development of process and/or program goals and performance measures.

This indicator may be met by:

Documents and work plans indicating goals and performance measures.

Documentation Required:

Example(s) of process and/or program goals and performance measures updated at least annually.

Evaluation Questions:

- How does your agency develop process and/or program goals and performance measures?
- Describe any tools, mechanisms or approaches your agency uses to develop process and/or program goals.

Indicator 2.2

Monitor progress towards process and/or program goals and performance measures.

This indicator may be met by:

Monitoring process and/or program goals and performance measures and progress toward meeting goals.

Documentation Required:

Materials that demonstrate process and/or program monitoring activities such as reports, data, meeting minutes, etc.

Evaluation Questions:

- What tools, mechanisms or approaches do you use for monitoring progress?
- How is progress monitored?

Section I-QI: Powers and Duties - Quality Improvement Supplement

Indicator 2.3

Evaluate the effectiveness of processes and/or programs and identify the opportunities for improvement.

This indicator may be met by:

- Collection and use of data or information in a systematic manner.
- Actions taken based upon the evaluation.

Documentation Required:

Copies of documents indicating how opportunities for improvement are identified. (Example includes NACCHO self-assessment results).

Evaluation Questions:

- How does your agency evaluate the effectiveness of processes and/or programs?
- How does your agency identify opportunities for improvement?

Indicator 2.4

Assure evaluation expertise is available.

This indicator may be met by:

Program evaluator on staff or consultant services in place.

Documentation Required:

Position description of agency evaluator or relationship/contract with evaluators.

Evaluation Question:

Describe your agency's mechanism to assure access to evaluation expertise.

Section I-QI: Powers and Duties - Quality Improvement Supplement

MPR 3

Implement quality improvement of public health processes and/or program goals.

Reference: *Essential Public Health Service #9*

Indicator 3.1

Establish a QI plan based on organizational policies and direction.

This indicator may be met by:

- Current QI policy to establish agency direction for improving agency processes and/or programs.
- Establishment and implementation of agency QI plan.

Documentation Required:

- Agency QI policy.
- Agency QI plan and how it is implemented.

Evaluation Questions:

- Describe your agency's process in establishing a QI plan.
- How does your agency implement the QI plan?

Indicator 3.2

Establish an ongoing QI process based on recommendations from the evaluation of processes and/or programs.

This indicator may be met by:

Use of a Plan-Do-Study-Act (PDSA) or an alternative method to address evaluation recommendations.

Documentation Required:

Example(s) of using a PDSA or an alternative method to improve a process and/or program as illustrated in the QI Guidebook, pgs. 24-28.

Evaluation Questions:

- How has your agency used evaluation findings to establish process or program improvements?

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- What quality improvement method(s) does your agency use to address evaluation findings and improve programs?
- How does your agency assure that improvement is ongoing?

Indicator 3.3

Assure QI training and technical assistance are available to staff.

This indicator may be met by:

QI training and technical assistance are available for staff and have occurred.

Documentation Required:

- Copies of QI training agenda, training materials and attendance roster.
- Evidence of staff availability for QI projects or an external consultant and how they provide employee QI technical assistance.

Evaluation Questions:

- How does your agency assure that QI training is available to employees?
- How does agency staff access QI technical assistance?
- What types of training has been offered in the past 12-24 months?

Plan Review

Michigan Local Public Health Accreditation Program
Tool 2014 – MPR Indicator Guide

Section II: Food Service

MPR 1
Plan Review

Materials necessary for auditing the MPR

- Plan review log book or tracking system
- Facility files selected for the review
- Department's program policy manual

Sample Selection:

- Use "Annex 6 - Office Sample Size Chart" to determine the number of records for review. The maximum sample size is ten.
- Follow "Annex 5 - Approved Random Sampling Methods" guide to select the sample.
- Using the logbook, randomly select the records for review for establishments that have been constructed, altered, converted, or remodeled since the last review cycle. If possible, do not select facilities that were reviewed using the April 28, 2003 memo for pre-existing food service establishments. Limit the sample to only those establishments for which the plans review process has been fully completed.

Program Indicators:

- Does the department review complete sets of plans and specifications?
  a. Application form/Transmittal letter
  b. Completed worksheet
  c. Menu
  d. Standard Operating Procedures (SOP)*
  e. Scaled drawings**
  f. Layout (plans)
  g. Ventilation hood locations (plans)
  h. Plumbing (For existing plumbing, documentation of review and approval is required. In absence of a plumbing plan, documentation must be made as to the adequacy of the system.)
  i. Lighting (For existing lighting, documentation of review and approval is required. In absence of a lighting plan, documentation must be made as to the adequacy of the system.)
  j. Equipment specifications

*Acceptable SOP Documentation:
1. A notation on the plan review checklist to indicate either:
   - SOPs have been submitted in compliance with the requirements of the Food Code; or
   - SOPs are not required (construction does not affect operation – i.e. new walk-in cooler).

OR

2. When SOPs are reviewed just prior to opening, notations on the pre-opening EVALUATION report to indicate that SOPs have been submitted in compliance with the requirements of the Food Code have been established.

OR

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Section II: Food Service

3. Use of the "SOP Cover Sheet" which was designed to document SOP review.

Actual SOP documents do not have to be maintained in the plan review file, since they may consist of CDs, videos, etc., or an office may maintain a copy of a chain's SOPs in a central file.

**Scaled drawings mean either:
1. Drawings that are proportional between two sets of dimensions (i.e. 1/4 inch of the drawing = 1 foot of the actual object); or
2. All objects on the drawing are proportional in size to each other. Dimensions are included.

- Is the plan review process properly documented?
    a. Use of a plan review checklist.
    b. Calculations to show what is needed and what is proposed for hot water, dry storage, and refrigerated storage for all establishments as well as documentation of approval for less than the required calculations.
    c. Applicant is informed in writing of any deficiencies.
    d. All identified deficiencies are addressed in writing or on revised plans.
    e. Plan approval letter is in the file that includes a description of the scope of the project, and references a unique identifier (I.E.: date) marked on the approved plans and specifications. See MDA "Model Plan Review Approval" letter for an example.

An establishment file will be considered to meet the standard when 80% of the program indicators reviewed are met. The evaluation may be terminated when 40% of the files selected for review indicate the MPR is "Not Met."

How to judge compliance with MPR I:

- **Met** – 80% of the establishment files evaluated indicate that the department reviews complete sets of plans, and properly documents the plan review process.

- **Not Met** – Overall, the plan review process does not assure complete sets of plans and the plan review process are poorly documented (give specific examples and percentages).

Tips for passing MPR 1:

- If plan review training is necessary, contact your Michigan Department of Agriculture (MDA) Plan Review Specialist. Use MDA's plan review manual, checklist, calculators, and other plan review form letters and materials.
- Organize the records to be audited. Arrange the files in chronological order. Fasten the material together so that it cannot fall out of the file and become disorganized. Discard materials that were either not required to be submitted or used during the review.
- Review the MDA's "Sanitarian Training Module on Plan Review."
- Conduct quality control evaluations of selected completed plan reviews.

Section II: Food Service

MPR 2
Pre-Opening Evaluations

Materials necessary for auditing the MPR

The files reviewed for MPR 1 – Plan review, are used to evaluate MPR 2.

Program Indicators:

- A copy of the pre-opening evaluation report is in the file.
- The evaluation report is dated either before or on the same day the license is signed.
- The evaluation report has a notation to indicate the establishment is approved to operate.
- The evaluation report verifies that there were no critical violations present prior to opening.

How to judge compliance with MPR 2:

- **Met** – 80% of the establishments reviewed had a properly documented pre-opening evaluation.

- **Met with Conditions** – Overall, pre-opening evaluations are being conducted for at least 80% of the establishments, but there are some minor concerns over documentation. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."

- **Not Met** – Less than 80% of the establishments received a pre-opening evaluation and/or documentation problems are commonplace.

Tips for passing MPR 2:

- Conduct pre-opening evaluations and document the results of the evaluation with the evaluation indicators for this MPR in mind.
- Remember to check the "pre-opening evaluation" box on the evaluation report form.
- File the inspection reports in chronological order in the file.

For technical assistance, please contact Sean Dunleavy at 517-243-8895 or dunleavys@michigan.gov

Section II: Food Service

MPR 3
Evaluation Frequency

Materials necessary for auditing the MPR

- MDA print-out of licensed establishments
- Local health department files
- Local health department database (optional)

Sample Selection:

- This sample of fixed food service establishments is used to evaluate MPRs 3, 6, 9, 10, and 12.
- Use "Annex 6 - Office Sample Size Chart" to determine the number of establishments for review.
- Follow "Annex 5 - Approved Random Sampling Methods" guide to select the sample from the MDA licensing print out.
- Where there are multiple offices, a proportional sample should be selected to reflect the percentage of establishments regulated by each individual office (i.e. 35% of the establishments are located in County A and 65% are in County B).
- From the sample selected, pick a subset of establishments for field review that meet the criteria for MPR 8.
- If possible, make certain the sample includes at least one (1) mobile food service establishment, one (1) STFU, and one (1) Vending file.
- Obtain the folder for each of the establishments in the sample.

Program Indicators:

- Discussion: Not all of the establishments in the sample require the same number of evaluations. Variations may be due to the fact that some establishments may have either opened or closed during the three year review period. Some may be seasonal operations. Some may have been evaluated shortly before the review period thus pushing the first evaluation 6 months back into the review period. Some may be using the Risked Based Evaluation Schedule (see MDA memo dated November 13, 2008.) The evaluation must take these factors into consideration.

- Evaluation Method (Example for facilities using a 6-month evaluation schedule.): Determine the number of evaluations that were required and actually conducted during the three year review period. Start with the first evaluation in the review period.

  Examples:
- Regular fixed: Count forward from the first evaluation in the review period in six-month intervals. At each interval, determine if an evaluation has been made. Allow one extra month grace period. Determine the percentage of evaluations that were made at the required intervals for each folder.

Example folder for Bill's Burgers	
Accreditation period:	February 10, 2003 – February 10, 2006
First Evaluation :	April 20, 2003
Next routine:	November 15, 2003 (ok < 7 months)
Next routine:	May 10, 2004
Next routine	Missed – no evaluations

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Next routine: April 30, 2005
Next routine: November 13, 2005 (ok, < 7 months from last evaluation)
Number of required Evaluations = 6
Number of evaluations conducted at proper frequency = 5
Percentage of evaluations: = 83%

- Seasonal fixed and low risk establishments: Determine if one evaluation was made during each operating season in the review period. (NOTE- Seasonal establishments have no set inspection schedule, and can be done any time throughout the operating season. If an RBE Schedule is used, the facility must be inspected on the established routine schedule. A seasonal fixed operation that is established under an RBE schedule to be evaluated every 12 months would need to show a frequency of every 12 months, not to exceed 13 months.) Determine the percentage of evaluations that were made at the required interval for each establishment.

Example folder for Seasonal Fixed: Clarkston Dairy Fill
Accreditation Period: February 10, 2003 – February 10, 2006
Operating period: May - October
First evaluations in period: May 20, 2003
Next routine: August 30, 2004
Next routine: September 30, 2005
Next routine: No evaluation (OK- not due until October 2006)
Number of evaluations due = 3
Number of evaluations conducted at proper frequency = 3
Percentage of evaluations = 100%

- Vending: One-third of each operator's vending machine locations are required to be evaluated each year. Every vending machine location must be evaluated over a three-year period. Since only one file will be evaluated during this review, a log of all vending locations, showing inspection dates, will be reviewed to demonstrate that inspections are done within the three-year period.

How to judge compliance with MPR 3:

- Evaluation frequency based upon Food Law, Section 3123
- An individual establishment will be considered to meet evaluation frequency when 80% of the required routine evaluations have been made (i.e. six evaluations required; five evaluations conducted).

- **Met** – 80% of the establishments in the sample meet evaluation frequency. Example: 22 establishments in sample, 18 establishments are required to meet evaluation frequency.
- **Met with Conditions** – Less than 80% of the establishments in the sample meet evaluation frequency; however, at least 80% of the total number of evaluations required for all of the establishments in the sample have been conducted. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 80% of the establishments meet evaluation frequency requirements. Less than 80% of the total number of evaluations required for all of the establishments in the sample have been conducted.

EVALUATION FREQUENCY USING A RISKED BASED EVALUATION SCHEDULE

A local health department may utilize an optional MDA "Risk Based Evaluation Schedule." For those agencies, evaluation frequencies will be audited utilizing that schedule. See Risked Based Evaluation Schedule, MDA memo dated November 13, 2008.

Section II: Food Service

Tips for passing MPR 3:

- Arrange files in chronological order.
- Schedule routine evaluations to be conducted one month prior to the next evaluation due date. This will allow a 60-day window for meeting the MPR.
- Plan ahead. Each local health department has the option of using a Risk Based Evaluation Schedule to manage their program more effectively. If a facility is on a reduced evaluation schedule, have the new schedule clearly designated so the auditor can determine frequency compliance. (Example: marked in the file or in a database, etc.)

MPR 4- (Vending) was eliminated from the MPR Indicators for Cycle 5.

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MPR 5
Temporary Food Establishment Evaluations

Materials necessary for auditing the MPR

Local health department temporary food service establishment files (licenses and evaluations) for the three-year review time period.

Sample Selection:

- Use the "Annex 6 – Office Sample Size Chart" to determine the number of records for review.
- Use "Annex 5 – Approved Random Sampling Methods" to select the sample.
- Use the total number of temporary food service establishment licenses issued over the past three years as the basis for determining sample size. (The annual number of licenses may be located on the MDA Annual Report. Use this number and multiply by three to obtain the number of licenses over the three-year review period.)
- Where there are multiple offices, a proportional sample should be selected to reflect the percentage of establishments regulated by each individual office (i.e. 35% of the establishments are located in County A and 65% are in County B).
- Select a proportional amount for each year reviewed.

Program Indicators:

- Determine if the local health department has conducted an operational evaluation of each temporary food service establishment prior to licensure.
- Determine if Sections A, B, the Food Column of Section F, Attachment A (when used) of the application (FI-231), and all fields of the license form (FI-229) have been completed. Determine if the temporary food service licensing records are complete with the evaluation date, the date the license was approved, and the sanitarian's signature.
- Determine if a temporary food service license was issued with unresolved critical violations.

An individual licensing record would not be considered to meet the standards if any one of the above conditions is observed.

How to judge compliance with MPR 5:

- **Met** – At least 80% of the licensing records in the sample meet the standards.
- **Met with Conditions** – Overall, operational evaluations are being properly conducted and there are no unresolved critical violations in at least 80% of the records in the sample; however, there are some occasional recordkeeping problems that tip the scale below the 80% cut-off. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 80% of the licensing records in the sample meet the standards.

Tips for passing MPR 5:

- Conduct an operational evaluation of all temporary food service establishments prior to licensure.
- Use the MDA "Food Service Establishment Evaluation Report," form (FI-214).

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- Review the application, license, and evaluation reports to make certain they are complete and accurate.
- Do not make notes on evaluation reports that resemble violations (i.e. hold all cold foods at 41°F and below). Use "Fact Sheets," "Temporary Food Establishment Operations Checklist," etc., to convey educational information.
- All critical violations must be corrected before issuing a Temporary Food Establishment License.
- Conduct quality assurance reviews of the completed licenses and evaluation.

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MPR 6
Evaluation Procedures

Materials necessary for auditing the MPR

The materials and sample used to evaluate MPR 3 and 5 are used to evaluate MPR 6.

Program Indicators:

- Determine if the Local Health Department uses an evaluation report form approved by the Michigan Department of Agriculture.
- Administrative information about the establishment's legal identity, address, and other information is entered on the evaluation report form.
- The report findings properly document and identify critical and noncritical violations.
- The evaluation report summarizes the findings relative to compliance with the law.
- The report is legible.
- The report conveys a clear message.
- The narrative clearly states the violations observed and necessary corrections.
- Timeframes for correcting critical and noncritical violations are specified.
- The evaluation report is signed and dated by the sanitarian.
- The evaluation report is signed by an establishment representative.

(Note: The pre-opening inspection that is marked "Approved to Open" is considered to be a routine inspection.)

An establishment folder will be considered to meet the standard when 80% of the evaluation records reviewed meet all of the above concerns (i.e. five out of six evaluation reports meet all of the standards).

How to judge compliance with MPR 6:

- **Met** – 80% of the establishments in the sample meet the standard.
- **Met with Conditions** – Critical and noncritical violations are being properly identified in 80% of the establishments. Approved evaluation report forms are used; however, occasional clerical omissions bring the compliance rate slightly below 80%. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 80% of the establishments in the sample meet the standard.

Tips for passing MPR 6:

- Use an approved computer generated evaluation report writing system.
- Use the MDA evaluation report form.
- Develop an in-house quality assurance system whereby a supervisor or trainer reviews reports periodically.

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- Do not write phrases on the report such as "OK" and "Corrected at time of evaluation" for critical violations. Document the specific action that has been taken to correct the critical violation. (i.e. The turkey left out at room temperature has been discarded. All potentially hazardous foods at the cook line will be stored in the prep cooler.)

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MPR 7

Identification of Interventions and Risk Factor Violations - Field Review

Materials necessary for auditing the MPR

- MDA licensing computer printout
- Local health department facility files
- Field review worksheet
- Office Worksheet

Sample Selection:

- This MPR evaluates the quality of evaluations conducted by local health department staff. The sample size is based upon the number of sanitarians conducting routine food service establishment evaluations.

Number of Sanitarians	Sample Size
1 to 5	10
6	12
7	14
8	16
9	18
10	20
11	22
12	24
13*	26

*The maximum field sample size is limited to 26 establishments regardless of the number of sanitarians. The size is limited to the number of establishments that two MDA staff members can inspect over a four-day period.

- From the random sample selected in MPR 3, select a sample of food service establishments in accordance with the MPR 6 sample selection chart.
- Special considerations: The establishments should be full-service, open for business during the evaluation period, and geographically located to allow an efficient use of travel time. The random sample list from MPR 3 may have to be expanded to meet these criteria.
- A copy of the field sample list is provided to the office reviewers.

Program Indicators:

- Each establishment folder is reviewed using the Office Worksheet to record the violations listed from the local health department's last routine evaluation report.
- The field reviewer will conduct a Risk Based Evaluation and complete a Field Review Worksheet report form for each establishment. Risk Based Evaluation techniques are detailed in the 2005 Food Code, Annex 5, Section 4, A-H.
- Table MPR 7 will be completed from the Office Worksheet.

- The MDA will use the following considerations in making judgments for identifying violations:

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a. Is the violation likely to have existed during the local health department's last evaluation? If so, the violation should be marked.
b. Does the violation appear to be either chronic or continuous? If so, the violation should be marked. The terms "chronic" and "continuous" are defined in MDA's "Model Enforcement Procedures."

- There may be circumstances for which the local health department may not be directly responsible due to isolated mistakes made at the time of the review by food service employees. If so, a violation should not be marked. For example:
    a. A cold item held above 41°F on the buffet in an establishment that otherwise clearly demonstrates compliance, knowledge, and proper procedures in time/temperature relationships.
    b. An employee handles ready-to-eat food with bare hands in a kitchen where other employees are appropriately avoiding bare-hand contact.
    c. The certified food manager temporarily leaves an unqualified person in charge during his/her absence.

- Assessing individual establishment pass/fail for intervention and risk factor violation identification: An individual evaluation report is considered to meet the standard when the last local health department evaluation report identifies at least 80% of the intervention and risk factor violations identified by the MDA (there are 14 categories of intervention and risk factor violations listed on the Office Worksheet and Field Review Worksheet report forms). Therefore, the local health department cannot miss more than three intervention and risk factor violation categories.

How to judge compliance with MPR 7:

- **Met** – At least 80% of the local health department's evaluation reports evaluated in the survey pass the standard.
- **Met with Conditions** - At least 70% but less than 80% of the evaluation reports evaluated in the survey passes the standard. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** - Less than 70% of the local health department's evaluation reports evaluated in the survey pass the standard, and/or an imminent health hazard is encountered in an operating establishment that was in existence during the previous evaluation, but was not identified on the local health department's evaluation report.

Tips for passing MPR 7:

- Make certain staff is appropriately trained to conduct risk based evaluations.
- Have inspectors document observed violations whether corrected at time of evaluation or not.
- Conduct internal quality assurance audits to make certain that staff is properly identifying intervention and risk factor violations and good retail practice violations.
- Follow the department's enforcement policy when continuous and chronic violations are observed.

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MPR 8

Evaluations Result in Food Code Compliant Establishments – Field Review

Materials necessary for auditing the MPR

- Use the same materials and sample used to audit MPR 7
- Table MPR 8 from the MDA document titled "Food Service Program Assessment Forms."

Program Indicators:

- Each establishment folder is reviewed using the office worksheet to record the violations listed from the local health department's last routine evaluation report.
- The field reviewer will conduct a risk based evaluation and complete a "field review worksheet" report form for each establishment. Risk based evaluation techniques are detailed in the 2005 Food Code, Annex 5, Section 4, a-h.
- Table MPR 8 will be completed from the office worksheet.

- The MDA will use the following considerations in making judgments for identifying violations:
    a. Is the violation likely to have existed during the local health department's last evaluation? If so, the violation should be marked.
    b. Does the violation appear to be either chronic or continuous? If so, the violation should be marked. The terms "chronic" and "continuous" are defined in MDA's "Model Enforcement Procedures."

    - There may be circumstances for which the local health department may not be directly responsible, due to isolated mistakes made at the time of the review by food service employees. If so, a violation should not be marked, for example:
        a. A cold item held above 41°F on the buffet in an establishment that otherwise clearly demonstrates compliance, knowledge, and proper procedures in time/temperature relationships.
        b. An employee handles ready-to-eat food with bare hands in a kitchen where other employees are appropriately avoiding bare-hand contact.
        c. The certified food manager temporarily leaves an unqualified person in charge during his/her absence.

    - The field reviewer will compare the field review worksheet with the office worksheet and mark the corresponding box on the office worksheet as follows:
        a. "x" denotes violations found during the field evaluation by MDA and not found by the local health department in the last routine evaluation.
        b. "√" denotes violations were also found by the local health department at last routine evaluation.
        c. "⊗" denotes violations for which formal enforcement is in progress (does not count toward determining % of compliance).

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How to judge compliance with MPR 8:

- **Met** – All violation categories on table MPR 8 are marked 60-100% in compliance.
- **Met with Condition** – One intervention or risk factor violation category on table MPR 8 is marked 41-59% in compliance OR one good retail practice violation category is marked 0-59% in compliance. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – One intervention or risk factor violation category on table MPR 8 is marked 0-40% in compliance, OR two or more of any violation categories on table MPR 8 are marked 0-59% in compliance.

Legal basis note: the Michigan Food Law, Section 3127, requires that:

1. Evaluation reports summarize findings relative to compliance with the act.
2. The findings be recorded on an evaluation form approved by the department.
3. That the forms identify those items considered to be critical from a public health standpoint.

Tips for passing MPR 7:

- Make certain staff is appropriately trained to conduct risk based evaluations.
- Have inspectors document observed violations whether corrected at time of inspection or not.
- Conduct internal quality assurance audits to make certain staff is properly identifying intervention and risk factor violations and good retail practice violations.
- Follow the department's enforcement policy when continuous and chronic violations are observed to ensure that violations are corrected and long-term compliance is achieved.

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MPR 9
Records

Materials necessary for auditing the MPR/Sample Selection

- The materials and sample used to evaluate MPRs 1- 6 and 10-20 are used to evaluate MPR 9.

Program Indicators:

- Records are maintained in accordance with "Annex 3 – Excerpt from MDCH General Schedule #7."
- The local health department staff is able to retrieve the records necessary for the audit.
- Applications and licenses are processed in accordance with law. Complete application information includes:
    a. The date of issuance
    b. The date(s) of operational inspections for STFUs
    c. Information required for vending and mobile license application sections
    d. Seasonal and/or license limitations sections completed
    e. Signatures (approved electronic signatures are acceptable) of the operator and signature of a person designated by the department and/or their assignees are provided

How to judge compliance with MPR 9:

- **Met** – No significant recordkeeping problems are noted.
- **Met with Conditions** – Overall, records are properly handled; however, some minor problems were identified which need to be addressed. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – The recordkeeping system is relatively unorganized. Obtaining records for the audit was somewhat difficult. License applications are not being processed in accordance with law.

Tips for passing MPR 9:

- Assign one person the responsibility for maintaining the filing system.
- Use "out-cards" when removing records from the filing system.
- Do not hold licensing materials. Process them immediately. Follow the enforcement procedure if there are problems preventing licensure.

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Enforcement

MPR 10
Enforcement Policy

Materials necessary for auditing the MPR

- Copy of the local health department's enforcement policy.
- The records and sample used to evaluate MPR 6.

Program Indicators:

- Determine if the enforcement policy affords notice and opportunity for a hearing equivalent to the Administrative Procedures Act, Act 306 P.A.1969.
- The policy is compatible with Chapter 8 of the 2009 Food Code, and the Michigan Food Law 2000.
- Determine if the department's policy has enforcement procedures for addressing unauthorized construction, operating without a license, imminent health hazards, continuous critical and noncritical violations, and recurring critical violations.
- Verify if the policy has been adopted and signed by the Health Officer.
- Review the past three years of evaluation reports from the sample of establishments to determine if the department's enforcement policy is being followed. An individual establishment folder will be considered to be in compliance when the appropriate action specified in the enforcement policy is taken to eliminate (see MDA's "Model Enforcement Policy" for definitions):
    - √ Operation without a license
    - √ Imminent health hazards
    - √ Continuous critical and non-critical violations
    - √ Recurring critical violations

How to judge compliance with MPR 10:

- **Met** – At least 80% of the establishment folders reviewed indicate the enforcement policy is being followed. An enforcement policy that meets the evaluation criteria has been adopted.
- **Met with Conditions** – An enforcement policy that meets the evaluation criteria has been adopted. At least 80% of the establishment folders indicate the enforcement policy is being followed; however, there is at least one example of a significant lack of enforcement action that could have public health consequences.
- **Not Met** – Less than 80% of the establishment folders indicate the enforcement policy is being followed. An enforcement policy that meets the evaluation criteria has not been adopted.

Tips for passing MPR 10:

- Use the MDA's "Model Enforcement Policy."
- Make certain that the model has been adopted by the health officer. The mere presence of a draft of the MDA model policy in a folder is not sufficient.
- Conduct routine quality assurance reviews to make certain staff are following the enforcement policy.

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MPR 11
Unauthorized Construction

Materials necessary for auditing the MPR/Sample Selection

- Use the same materials and sample selected for MPRs 1 and 2.

Program Indicators:

- Construction is not allowed prior to plan approval.
- Stop work orders and other enforcement actions are taken when construction related problems are observed.

How to judge compliance with MPR 11:

- **Met** – The records indicate that when the department learns that construction is occurring prior to plan approval, appropriate action is taken.
- **Met with Conditions** - Overall the department is taking action to prevent construction prior to plan approval, but there are one or two technical aspects that need to be addressed. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – More than one of the records reviewed showed the department to be ineffective in preventing construction prior to plan approval.

Tips for passing MPR 11:

- Follow the department's enforcement policy whenever unauthorized construction is observed.
- Take immediate action.
- Use Stop Work Orders.
- Document the process.
- Develop a working relationship with the local building department.

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MPR 12
Follow-up Evaluation

Materials necessary for auditing the MPR/Sample Selection

- The materials and samples used to evaluate MPR 3 are used to evaluate this MPR.

Evaluation:

- A follow-up evaluation shall be conducted by a local health department, preferably within 10 calendar days, but no later than 30 calendar days, to confirm correction of all previously identified critical violations.
- Information about the corrective action is described on the evaluation report. This includes violations that are corrected at the time of evaluation.
- A separate report form is used to record the results of the follow-up evaluation.
- An individual establishment will be considered to meet the standard when 80% of the follow-up evaluations are conducted within 30 calendar days, and information about the corrective action is described on a separate evaluation report.

How to judge compliance with MPR 12:

- **Met** - at least 80% of the establishments in the sample meet the standard.
- **Not met** - less than 80% of the establishments in the sample meet the standard.

Tips for passing MPR 12:

- Create a tracking system to assure that follow-up evaluations are conducted.

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MPR 13
License Limitations

Materials necessary for auditing the MPR

- Local health department policy manual
- Local health department list of establishments having licenses limited during the review period.

Sample Selection:

- Ask the local health department for a list of establishments having a license limitation issued during the review period.

Program Indicators:

- Determine if the reasons for limiting a license are in accordance with the Food Law:
    a. The site, facility, sewage disposal system, equipment, water supply, or the food supply's protection, storage, preparation, display, service, or transportation facilities are not adequate to accommodate the proposed or existing menu or otherwise adequate to protect public health.
    b. Food establishment personnel are not practicing proper food storage, preparation, handling, display, service, or transportation.

- Determine if proper notice of the limitations have been provided to the applicant along with an opportunity for an administrative hearing.
- Determine if the license application is appropriately completed to indicate the establishment has a limited license.

How to judge compliance with MPR 13:

Note: It is unlikely that many licenses will have been limited over the three (3) year review cycle; therefore, a percentage allowance is not feasible.

- **Met** – The department issues limited licenses in accordance with the Food Law.
- **Met with Conditions** – Overall the department issues limited licenses in accordance with the Food Law, but there are some minor deviations that need attention. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – The department does not issue limited licenses in accordance with the Food Law.

Tips for passing MPR 13:

- Develop a form letter for issuing limited licenses that includes legal notice requirements.
- Develop an internal review procedure that promotes uniformity.

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MPR 14
Variances

Materials necessary for auditing the MPR

- Local health department policy manual.
- Local health department list of variances evaluated during the review period.

Sample Selection:

- Ask the local health department for a list of establishments having been issued a variance during the review period.

Program Indicators:

- Determine if variances are required for specialized processing methods as required by Section 3-502.11 of the Food Code.
- Determine if the applicant's variance request is maintained in the file.
- Determine if the applicant has provided a statement of the proposed variance of the Food Code citing relevant code section numbers, an analysis of the rationale for how the public health hazards addressed by relevant code sections will be alternately addressed by the proposal, and a HACCP plan if required.
- Determine if the department has a formal procedure for issuing variances.
- Determine if staff is following the department's procedures.

How to judge compliance with MPR 14:

Note: It is unlikely that many variances will have been issued over the three-year review cycle; therefore, a percentage allowance is not feasible.

- **Met** – The department issues variances in accordance with the Food Code.
- **Met with Conditions**– Overall the department issues variances in accordance with the Food Code but there are some minor deviations that need attention. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – The department does not issue variances in accordance with the Food Code.

Tips for passing MPR 14:

- Develop in-house procedures for issuing variances.
- Form an internal review procedure that promotes uniformity.

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MPR 15
Consumer Complaint Investigation (non foodborne illness)

Materials necessary for auditing the MPR

- Local health department complaint tracking system
- Selected complaint files
- Local health department policy manual

Sample Selection:

- Use "Annex 6 - Office Sample Size Chart" to determine the number of records for review.
- Follow "Annex 5 - Approved Random Sampling Methods" guide to select the sample from the complaint tracking system.
- Use the total number of complaints received over the past three years as the basis for determining sample size.

Program Indicators:

- Determine if a consumer complaint tracking system has been created.
- Determine if consumer complaint investigations are initiated within 5 working days.
- Determine if the local health department responds to anonymous consumer complaints in accordance with their policy.
- Determine if the findings (a brief notation that explains the results and conclusions of the investigation) are noted either in the logbook or on the filed complaint record.

How to judge compliance with MPR 15:

- **Met** – The department maintains a consumer complaint tracking system. At least 80% of the records reviewed indicate the department initiates complaint investigations within five working days and documents the findings.
- **Met with Conditions** - The department maintains a consumer complaint tracking system. At least 80% of the records reviewed indicate the department initiates investigations within five working days, but there are some minor documentation problems. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – The department does not maintain a complaint log book and/or less than 80% of the records reviewed indicate the department initiates complaint investigations within five working days, and/or the department does not documents the findings.

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Staff Training and Qualifications

MPR 16
Technical Training

Materials necessary for auditing the MPR

- Training files for every new employee hired, or assigned to the food service program during the last review period

Sample Selection:

- The training record for each employee is reviewed.

Program Indicators:

- Determine if the training record indicates each individual has completed training in the six designated skill areas.
    a. Public health principles
    b. Communication skills
    c. Microbiology
    d. Epidemiology
    e. Food Law, Food Code, related policies
    f. HACCP) within 12 months of being assigned to the program.

- The local health department's judgment as to the completeness and complexity of the training for each skill area must be documented.
- See the tips section below for recommended evaluation of a new sanitarian that has completed training at another local health department.

Note: Employees only involved in the evaluation of specialty food service establishments are not included in the evaluation for MPR 15.

How to judge compliance with MPR 16:

- **Met** – The training record for each employee indicates that training has been completed in the six designated skill areas within 12 months from the date of being assigned to the program.
- **Met with Conditions** - The training record for each employee indicates that training has been completed in the six designated skill areas, but the training period exceeded 12 months from the date of being assigned to the program. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Either training records are not maintained or the records indicate that training has not been completed in the six designated skill areas.

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Tips for passing MPR 16:

- Completion of recommended ORA U. curriculum or equivalent courses.
- To assess the technical training of a newly hired / newly assigned food inspector, use the Technical Training section of the MDA: FOOD PROGRAM TRAINING NEWLY HIRED / NEWLY ASSIGNED FOOD PROGRAM INSPECTORS: (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mda/0,1607,7-125-50772_50775_51204---,00.html)
- To assess the technical training of a Previously Trained / Experienced Inspector, use the Technical Training Requirements section of the MDA: FOOD PROGRAM TRAINING - Assessing the Risk Based Inspection Skills of a Previously Trained / Experienced Inspector (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mda/0,1607,7-125-50772_50775_51204---,00.html)

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MPR 17
Fixed Food Service Evaluation Skills

Materials necessary for auditing the MPR

- Training files for every new employee hired or assigned to the food service program during the last review period.

Sample Selection:

- The training record for each employee is reviewed.

Program Indicators:

- Determine if the training record indicates if 25 joint evaluations, 25 independent evaluations under the review of the trainer (either on-site or paperwork review), and five evaluation inspections have been conducted with the standardized trainer within 12 months of employment or assignment to the food program. Employees only involved in the evaluation of specialty food service establishments are exempt.
- See the tips section below for recommended evaluation of a new sanitarian that has completed training at another local health department.

How to judge compliance with MPR 17:

- **Met** - The training record for each employee indicates 25 joint evaluations with the standardized trainer, 25 independent evaluations under the review of the standardized trainer, and five evaluation inspections have been conducted with the standardized trainer within 12 months of employment or assignment to the food program.
- **Met with Conditions** – The training record for each employee indicates 25 joint evaluations, 25 independent evaluations under the review of the trainer, and five evaluation inspections have been conducted with the standardized trainer, but there is evidence that independent evaluations were being conducted prior to the completion of training. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met".
- **Not Met** – Either training records are not maintained or the records indicate 25 joint evaluations, 25 independent evaluations, and five evaluation inspections have not been completed within 12 months of employment or assignment to the food program, and the employee is conducting independent evaluations.

Tips for passing MPR 17:

- A training assessment is recommended for a sanitarian new to a department who has become qualified and experienced while working in another local health department. The assessment should consist of a document review of the inspector's credentials as well as a field skill review. A training plan should be developed based on the review. To assess the training of a newly hired / newly assigned food inspector, use the Fixed Food Service Evaluation Skills Training section of the MDA: FOOD PROGRAM TRAINING - NEWLY HIRED / NEWLY ASSIGNED FOOD PROGRAM INSPECTORS: (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mda/0,1607,7-125-50772_50775_51204---,00.html)

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- To assess training of a Previously Trained / Experienced Inspector, use the Fixed Food Service Evaluation Skills Training Requirements section of the MDA: FOOD PROGRAM TRAINING - Assessing the Risk Based Inspection Skills of a Previously Trained / Experienced Inspector: (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mda/0,1607,7-125-50772_50775_51204---,00.html)

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MPR 18
Specialty Food Service Evaluation Skills

Materials necessary for auditing the MPR

- Supervisor endorsement for every newly assigned employee to the specialty food service program. Employees include those who may be occasionally asked to evaluate specialty food service establishments (temporary, STFU, vending, mobile).

Sample Selection:

- Supervisor endorsement for each employee is reviewed.

Program Indicators:

- Determine if the supervisor has endorsed all employees who evaluate specialty food service establishments (mobile, vending, STFU, temporary) as having knowledge of the Food Law, Food Code, public health principles, and communication skills. Each employee must be endorsed for each type of specialty food service facility they evaluate.

How to judge compliance with MPR 18:

- **Met** – Supervisor endorsement for each newly assigned employee involved in the evaluation of specialty food service establishments is completed before conducting independent evaluations.
- **Met with Conditions** - The supervisor endorsement for each newly assigned employee involved in the evaluation of specialty food service establishments is completed, but a newly assigned employee conducted independent evaluations prior to supervisor endorsement. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Supervisor did not evaluate and endorse a newly assigned inspector before conducting independent evaluations for each type of assigned establishment.

Tips for passing MPR 18:

- Develop a formal written training plan for employees occasionally assigned to various aspects of the program.
- Maintain a training folder for each employee.

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Foodborne Illness Investigations

MPR 19
Foodborne Illness Investigations - Timely response

Materials necessary for auditing the MPR

- Local health department foodborne illness investigation policy manual
- Complaint log or tracking system
- MDA list of local health department foodborne illness investigation reports
- Foodborne illness investigation records generated since the last accreditation review

Sample Selection:

- A maximum random sample of 10 foodborne illness investigation records for the review period will be evaluated.

Program Indicators:

- Determine if foodborne illness complaint investigations are initiated within 24 hours. "Initiated" includes the initial contact, phone calls, file reviews, etc., made by the person responsible for conducting the investigation.
- Determine if the local health department has submitted a copy of the final written report to the MDA within 90 days after the investigation has been completed.

How to judge compliance with MPR 19:

- **Met** – At least 80% of the foodborne illness investigations records reviewed contain all of the following elements: a) all foodborne illness complaint investigations are initiated within 24 hours, and b) all final written reports are submitted to MDA within 90 days of investigation completion.
- **Met with Conditions** – Compliance with the above 70% of the time. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Compliance with the above less than 70% of the time.

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MPR 20
Foodborne Illness Investigations - Procedures

Materials necessary for auditing the MPR

- Local health department foodborne illness investigation policy manual
- Complaint log or tracking system
- Documentation of complaint log/tracking system reviews
- MDA list of local health department foodborne illness investigation reports
- Foodborne illness investigation records generated since the last accreditation review

Sample Selection:

- A maximum random sample of 10 foodborne illness investigation records for the review period will be evaluated.

Program Indicators:

- Determine if the complaint log or tracking system is systematically reviewed to determine if isolated complaints may indicate the occurrence of a foodborne illness outbreak.
- Determine if the department has and follows standard operating procedures for foodborne disease surveillance and investigating foodborne illness outbreaks that include:
    a. A description of the foodborne illness investigation team and the duties of each member.
    b. Identify the frequency for reviewing the complaint log or tracking system for trends, who will review it, and how the reviews will be documented.
    c. Outline the methods used to communicate foodborne illness information with local health department employees, other governmental agencies, and organizations.

- Determine if the department uses procedures consistent with those contained in "Procedures to Investigate a Foodborne Illness," 5th edition, published by the International Association for Food Protection.
- Determine if the department is using the proper forms for investigating foodborne illness complaints.
- Determine if the department follows the MDA February 3, 2006, memo, titled: "Foodborne Illness Reporting and Documentation for Minimum Program Requirement Compliance."

How to judge compliance with MPR 20:

- **Met** – Standard operating procedures that meet MPR 20 are in place and are followed.
- **Met with Conditions** – Overall the department has and follows standard operating procedures that meet MPR 20 however, some minor exceptions need to be addressed. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Written operating procedures that meet MPR 19 have not been provided and/or the procedures outlined in MPR 19 for investigating foodborne illness outbreaks are not being followed.

Section II: Food Service

Tips for passing MPRs 19 and 20:

- Recommend completion of Basic online F.I.R.S.T. training available through MITRAIN.
- Staff conducting foodborne illness investigations should periodically review "Procedures to Investigate Foodborne Illness, 5th edition."
- Assemble the foodborne illness investigation team at least once annually to review procedures.
- Contact local governmental agencies and organizations at least annually to review foodborne illness reporting and investigation responsibilities. Be certain to include local hospitals and the medical community in the policy.

Section II: Food Service

Important Factor I
Industry and Community Relations (Equivalent to FDA Retail Standard 7)

Materials necessary for auditing the Important Factor I

- Documentation to provide evidence of annual surveys or meetings held with industry and community for the purpose of soliciting food service program related recommendations and feedback.
- Evidence of educational outreach to industry and community groups.
- Completion of the attached forms is recommended.

Program Indicators:

- Industry and Consumer Interaction
    a. The jurisdiction sponsors or actively participates in meetings such as food safety task forces, advisory boards, or advisory committees.
    b. These forums shall present information on food safety, food safety strategies, and interventions to control risk factors.
    c. Offers of participation must be extended to industry and consumer representatives.

- Educational Outreach
    a. Outreach encompasses industry and consumer groups as well as media and elected officials.
    b. Outreach efforts may include industry recognition programs, web sites, newsletters, *Fight BAC!*™ campaigns, food safety month activities, food worker training, school-based activities, customer surveys or other activities that increase awareness of the risk factors, and control methods to prevent foodborne illness.
    c. Outreach activities may also include posting inspection information on a web site or in the press.

- Outcome
    a. The desired outcome of this standard is enhanced communication with industry and consumers through forums designed to solicit input to improve the food safety program.
    b. A further outcome is the reduction of risk factors through educational outreach and cooperative efforts with stakeholders.

- Documentation
    a) Quality records needed for this standard reflect activities over the most recent three-year period and include:
        1. Minutes, agendas or other records that forums were conducted.
        2. For formal, recurring meetings, such documents as bylaws, charters, membership criteria and lists, frequency of meetings, roles, etc.
        3. Documentation of performed actions or activities designed with input from industry and consumers to improve the control of risk factors.
        4. Documentation of food safety educational efforts. Statements of policies and procedures may suffice if activities are continuous, and documenting multiple incidents would be cumbersome, i.e., recognition provided to establishments with exemplary records or an on-going web site.

Section II: Food Service

How to judge compliance with Important Factor I:

- **Met** –Agency participation in at least one activity listed under program indicator A (industry and community relations) and B (educational outreach) annually is sufficient to meet this standard.

Tips for passing Important Factor I:

- Example: Hold an annual meeting with a school or school district in your jurisdiction (industry involvement); invite the parent / teacher organization (community involvement); and discuss food safety and interventions to control risk factors.
- Place food safety information on the department's web site.

Section II: Food Service

Chart showing compliance with Important Factor I:

Industry And Consumer Interaction Forums

Forum Title	Regulatory Participants By Organization	Industry Participants By Organization	Consumer Participants By Organization	Meeting Dates	Summary Of Activities Related To Control Of Risk Factors

Educational Outreach

Dates	Summary Of Activities

Other Outreach Activities
Please List Any Additional Outreach Activities Of Note Below.

Dates	Summary Of Activities

For technical assistance, please contact Sean Dunleavy at 517-243-8895 or dunleavys@michigan.gov

Section II: Food Service

Important Factor II
Continuing Education and Training

Materials necessary for auditing the Important Factor II

- Certificates earned from the successful completion of course elements of the uniform curriculum.
- Contact hour certificates for continuing education.
- Other employee training records.

Program Indicators:

- Each employee conducting inspections accumulates 20 contact hours of continuing education every 36 months after the initial training (18 months) is completed. The candidate qualifies for one contact hour for each hour's participation in any of the following activities:
    a. Attendance at regional seminars / technical conferences
    b. Professional symposiums / college courses
    c. Workshops
    d. Food-related training provided by government agencies

- The number of contact hours of training can be pro-rated for employees who have been on the job less than the 36-month Review Period. Employees who have limited food service responsibilities (i.e. inspect only temporary food service, vending, or seasonal food service) are not obligated to meet Important Factor II requirements.

How to judge compliance with Important Factor II:

- **Met** – Every employee assigned to the food service program has received at least 20 contact hours of training every 36 months after the initial training (18 months) is completed.

Section II: Food Service

Important Factor III
Program Support

Materials necessary for auditing the Important Factor III

- The total number of full time employees (FTE) assigned to the food service program.
- The total number of licensed food service establishments.

Comment:

- Important Factor III is derived from the U.S. Food and Drug Administration "National Recommended Retail Food Regulatory Program Standards; Standard 8 – Program Support and Resources." The FDA Standard 8 requires a staffing level of one FTE devoted to the food program for every 280 to 320 evaluations performed. Evaluations for the purpose of this calculation include routine evaluations, re-evaluations, complaint investigations, outbreak investigations, follow-up evaluations, risk assessment reviews, process reviews, variance process reviews, and other direct establishment contact time such as on-site training.
- An average workload figure of 150 establishments per FTE, with two evaluations per year, was originally recommended in the "1976 Food Service Sanitation Manual." Annex 4 of the Food Code since 1993, has included a recommendation that 8 to 10 hours be allocated for each establishment per year to include all of the activities reflected here in the definition of an evaluation. The range of 280 to 320 broadly defined evaluations per FTE is consistent with the previous recommendations.
- The 2003 Accreditation Tool standard indicated a staffing level of 125 to 225 establishments per FTE met the "Important Factor V – Program Support and Resources" standard.

Program Indicators:

- Determine the actual number of FTEs assigned to the food service program.
- Determine the number of FTEs needed to evaluate all annually licensed food service establishments (except temporary food service establishments).
    a. Recommended number of FTEs: Divide the total number of licensed establishments by 150.
    b. Minimum number of FTEs: Divide the total number of licensed establishments by 225.
- Determine the average number of FTEs required to evaluate temporary food service establishments. Divide the total number of temporary food service licenses issued per year by 300.
- Determine if the department is on a Risk Based Inspection Schedule.

How to judge compliance with Important Factor III:

- **Met** – The actual number of FTEs assigned to the food service program meets or exceeds the calculated minimum number of FTEs required. (Minimum number FTEs for annually licensed establishments plus average number for temporary food service establishments.)

Section II: Food Service

Important Factor IV
Quality Assurance Program

Materials necessary for auditing the Important Factor IV

- Local health department quality assurance written procedures.
- Employee training and quality control records

Program Indicators:

- Determine if:
    a. A written procedure has been developed that describes the jurisdiction's quality assurance program and includes a description of the actions that will be implemented if the review identifies deficiencies in quality or consistency.
    b. The quality assurance program includes a review of a least 10 evaluation reports for each sanitarian and/or an equivalent sample of foodborne illness investigation records every 24 months.
    c. Every employee assigned to the food service program has completed at least three joint evaluations with the standardized trainer every 36 months.
    d. The quality assurance program assures that evaluation reports are accurate and properly completed, regulatory requirements are properly interpreted, variances are properly documented, the enforcement policy is followed, foodborne illness investigations are properly conducted, and foodborne illness reports are properly completed.

How to judge compliance with Important Factor IV:

- **Met** – A written quality assurance program has been developed. A quality assurance review is conducted at least once every 24 months. At least 10 evaluation reports for each sanitarian's food evaluation and/or foodborne illness investigation records have been reviewed. Every employee assigned to the food service program has completed at least three joint evaluations with the trainer every 36 months.

Section II: Food Service

Annex 1 - Corrective Plan of Action

A corrective plan of action (CPA) is expected from a local health department for each MPR indicator that has been found "Not Met" during the evaluation. The accreditation program procedure requires the original CPA to be submitted to the accreditation administrative staff. To expedite review and acceptance by the MDA, local health departments are encouraged to send a copy directly to the MDA as soon as the CPA is completed.

Deadline for Submission
The Accreditation Program Protocols and Policies 2002 states, "local health departments must submit corrective plans of action to the Accreditation Program within two months of their on-site review." For more information on the Accreditation Program Protocols and Policies, see http://www.acreditation.localhealth.net/.

1. **Content**
   - For each "Not Met" MPR, the written corrective plan of action must include:
     a. A statement summarizing the problem (i.e. 45% of the food service establishments are presently being evaluated at the required frequency).
     b. A statement summarizing the standard (i.e. all food service establishments are required to be evaluated once every six months).
     c. A detailed plan for correcting the problem, including the names of the individuals responsible for each task, training needs, time lines, etc.
     d. A procedure for monitoring the plan to make certain the plan is being carried out as intended.
     e. A description of the corrective action that will be taken if the plan is not followed.
     f. A method for evaluating results and for basing a request to the MDA to conduct an on-site follow-up to verify that the plan has worked.

2. **Follow-up Review**
   - Within no less than 90 days and no longer than one year of the accreditation review, the local health department must submit a written request for the MDA to conduct a follow-up review to demonstrate compliance with the "Not Met" indicators. A minimum of 90 days of continuous compliance is required for the indicator to be found "Met."

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Copy of Form Found On the MPHI Accreditation Site for Completion of CPA

Instructions and Guidance:

- Please send any additional materials to accompany this Corrective Plan of Action directly to the reviewer(s) whom performed the applicable section review.
- If local health department staff need assistance in developing Corrective Plan(s) of Action please contact the applicable section reviewer(s).
- The Corrective Plan(s) of Action must be submitted by the local health department within 60 days of the last day of the On-site Review.
- Follow-up action on the Corrective Plan(s) of Action must take place within 365 days of the last day of the On-site Review.
- In order to complete the Corrective Plan of Action submission process, the health officer must login to the Web Reporting Module using their health officer account. Once logged in, the health officer may make any final edits necessary to the form and then publish the form by checking the 'Publish' box and clicking the 'Save' button.

Date: _____

Local Health Dept Name: _____

Your Name: * _____

Title: * _____

Local Health Department Staff Responsible for Implementing Corrective Plan of Action

Name: * _____

Title: * _____

Phone: * * _____

Fax: * * _____

Indicator Not Met

Indicator Description: _____

Corrective Plan of Action (be specific and include details)
Describe Corrective Plan of Action:* *

Projected Completion Date: _____

Please explain how the Corrective Plan of Action will correct the deficiency:* *

Section II: Food Service

Corrective Plan of Action (CPA) (be specific and include details):
Describe CPA
Include projected completion date of CPA
Explain how the proposed CPA will correct the deficiency

Are there additional materials accompanying this CPA:

● Yes ● No

Electronic Signature:*

NOTICE: By placing your name in this box, you agree that this plan has been reviewed and approved by appropriate administrative staff, including your Health Officer.

☑ Publish

Save

Return to CPA Page

Section II: Food Service

Element 1 (problem summary): The accreditation review determined that 70% of restaurants reviewed had consumer advisory violations and 60% of restaurants reviewed had date marking violations. Indicator 2.8 guidance states that no violation category can be identified in the field review in more than 40% of the establishments visited.

Element 3 (detailed plan):

A. Within seven days of the MDA's acceptance of the CPA, the Environmental Health (EH) Director will convene a staff meeting for the five staff involved in routine evaluations of food establishments. This meeting will discuss and begin implementation of the CPA.
B. The agency has just completed sending each food establishment: a consumer advisory pamphlet; an MDA date marking fact sheet; and a cover letter outlining the problem, explaining the need for increased attention to these two areas by operators, explaining the public health reasons for these requirements, and advising operators of the increased focus on these areas during upcoming evaluations. In addition, copies of these documents will be carried by inspectors during routine evaluations for distribution as needed.
C. Within 20 days of acceptance of the CPA, the agency standardized trainer will conduct a four-hour, office-based training on date marking and consumer advisory requirements. The training will involve sanitarians completing practical exercises to improve skills in problem areas. Our MDA area consultant will be asked to review the training curriculum in advance.
D. The agency standardized trainer will initially conduct three joint evaluations with each sanitarian within the first 30 days after completion of office training to assure that the date marking and consumer advisory requirements are being applied properly and uniformly. The joint visits will be made to the same types of facilities that were visited during the MDA review.
E. Staff will cite violations observed during routine evaluations for date marking and consumer advisories, inform establishments, in writing, of requirements for correction and conduct follow-ups as necessary to assure compliance.
F. Enforcement action according to the agency enforcement policy will be conducted against establishments which fail to correct date marking and consumer advisory violations. In summary, the enforcement steps are: If a violation is noted on two routine evaluations and corrected each time or if a violation is not corrected after the first follow-up evaluation, the sanitarian will work with the PIC to develop and implement a RISK CONTROL PLAN. Should the risk control plan not be effective in gaining long-term compliance, an office conference will be held as the first step in progressive enforcement.
G. A follow-up mailing to licensed establishments will be made after the MDAs next review to advise (and hopefully praise) industry of the success of their efforts. This follow-up will be incorporated into the department's food safety newsletter sent approximately twice per year.

Element 4 (monitoring procedure):

A. An office quality assurance review will be conducted by the EH Director and standardized trainer. Files for full-service establishments will be selected for review. The review will determine that consumer advisory and date marking violations are properly documented and corrected.
B. A trend analysis will be conducted to determine the percentage of facilities receiving violations for the two problem areas, to determine consistency between staff, determine violation percentages for full service facilities as compared to the MDA evaluation report and track trends over time.

C. The agency standardized trainer will initially conduct a minimum of one joint evaluation with each sanitarian approximately 90 days after completion of the previous joint evaluations to assure that the date marking and consumer advisory requirements are being applied properly and uniformly. The joint visits will be made to the same types of facilities that were visited during the MDA review.

Element 5 (correction if plan not followed): Additional training will be provided for specific staff as needed, based on the monitoring plan results.

Element 6 (Method for verification): Once the office and field reviews determine that the plan has been successful in reducing the level of violation for the problem areas in full service facilities to less than 20%, and within the one year follow-up deadline, an MDA revisit will be requested.

Annex 2 - Moot Point Principle

The Principle
The principle applies when an MPR deficiency has been detected by the local health department during a review cycle through the normal quality assurance process, action has been taken to correct the deficiency, and there is no likelihood that the deficiency will recur.

Application
The MPR in question is considered to be "Met" providing the following elements are documented and demonstrated:
The deficiency has been completely corrected and in place for at least 12 months prior to the evaluation.
The deficiency is not likely to recur.

Example showing when a moot point principle is applicable: Concrete steps have been taken to prevent recurrence.

Problem: Evaluations were not being conducted at the proper frequency.
Solution: One additional sanitarian was assigned to the program. A computer tracking system has been installed. Computer generated reports are routinely evaluated by management. Corrective action is taken as needed. Evaluations are now being conducted at the proper frequency.

Example showing when a moot point principle is not applicable: Improvements are noticed but concrete action to prevent recurrence is not documented.

Problem: Evaluations were not being conducted at the proper frequency.
Solution: Evaluation frequency was satisfactory during the 12-month period prior to the review. There is no documented management oversight system or other improvements to explain why the change occurred and why the problem will not recur.

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Annex 3 – Excerpt from MDCH General Schedule #7

Record Type	Minimum Retention Period (Years)
Evaluation Reports	CR + 5
License Applications	CR + 5
Annual Food Service Establishment Licenses	CR + 5
Routine Correspondence	CR + 3
Temporary Food Establishment Licenses	CR + 3
Legal Documents	CR + 10
Enforcement Actions	CR + 10
Food Outbreak Investigations	CR + 5
Water Supply Information	PERM – May destroy after 3 years if the establishment is connected to municipal water
Sewage Disposal Information	PERM – May destroy after 3 years if the establishment is connected to municipal sewer
Construction Plans & Specifications	5
Permanently closed establishment Plans and Specifications	3
Consumer Complaints	CR + 3

CR = Creation
PERM = Permanent

Reference: Michigan Food Law 2000, as amended Section 3121(2), (3), (4)

Section II: Food Service

Annex 4 - Procedure for Conducting Accreditation Re-evaluations of Local Health Departments

Purpose
To determine if a local health department has met the minimum program requirements (MPRs) that were found to be "Not Met" during the initial accreditation evaluation.

Background
The Michigan Local Public Health Accreditation Program requires a local health department to request a re-evaluation for all MPRs that were found to be "Not Met" between 90 days and one year of the accreditation review. Failure to request a re-evaluation within one year will result in "Not Accredited" status.

Re-evaluation to Determine Compliance Using Option 1 or 2

Option 1 MDA will follow the Policy/Procedure and Evaluation described below to evaluate the MRP as Met / Not Met / Met with Conditions

Option 2 OFFICE: With the use of Option 2, the only time MDA would do an accreditation revisit would be if the CPA put in place and evaluated after at least 90 days by the local health department was not effective.

FIELD: Since a self-assessment is not done by the local health department for Option 2 (QA should show field compliance) the local health department staff is evaluated during the accreditation visit. If MPR 7 or 8 receives a Not Met, a CPA and revisit are required. This would entail the MDA auditor to accompany and re-evaluate all staff who participated in the Option 2 field review.

Policy/Procedure
- The re-evaluation will assess only those MPRs found to be "Not Met" during the initial evaluation.
- The re-evaluation will encompass the time period beginning with the implementation of the CPA.
- For review of office MPRs: "Annex 6 - Office Sample Size Chart" and "Annex 5 - Approved Random Sampling Methods" guide will be used. Files selected for review will be limited to those reflecting work performed under the CPA. The re-evaluation may intentionally include previously reviewed records and establishments in order to assess progress.
- For review of Field MPRs: Facilities chosen for the initial accreditation review, that did not meet the requirements during the initial assessment, will be again assessed for compliance.

Evaluation
MDA will review the following:
- The deficiencies found in the original evaluation
- The CPA
- The action taken to resolve the deficiencies
- Results of the action

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How to Judge Compliance

- **Met** - The program indicator meets the definition of "Met" in the MPR Indicator Guide used during the original evaluation.
- **Met with Conditions** - Substantial progress has been made. Continued implementation of the CPA will reasonably result in compliance.
- **Not Met** - Not in compliance without a reasonable expectation of being in compliance in the near future.

Exit Interview

An exit interview will be conducted with the appropriate management staff.

Notification

MDA will enter the results of the re-evaluation into the MPHI accreditation website.

Waiver of On-Site Review

The MDA may waive the on-site review if it is possible to determine compliance from documentation submitted to MDA.

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Annex 5 - Approved Random Sampling Methods

Random number sampling introduces less bias than any other sampling method available. The objective is that every item on the list being used has an equal chance of being selected. For accreditation, the MDA uses a simple random sampling method to draw all samples. The MDA may place criteria on certain samples, thereby rejecting the selected document or file as not meeting predefined criteria, and then randomly selecting another, until one is drawn that meets the criteria.

See the Self-Assessment Guidance Document for examples.

To use a random selection method, it is necessary to have a list of the items to be selected from (i.e. licensed establishment list, plan review log, complaint log, etc.)

Method #1: Random number generating calculator, computer software, or hard copy random number table.

Select random numbers between the minimum and maximum number from the list being used. For example, you have a list of 175 fixed food service establishments, and you want to select five establishments from the list.

Use the calculator, software, or random number table to select five random numbers from 1 to 175. Should the same number be generated twice, reject the duplicate and select another random number. For example, let's say the numbers selected are: 32, 86, 12, 143, and 106. You would then count from the beginning of the establishment list and choose the 12th, 32nd, 86th, 106th, and 143rd establishments.

Method #2: Select every Kth facility

Select random numbers between the minimum and maximum number from the list being used. For example, you have a list of 175 fixed food service establishments, and you want to select five establishments from the list.

1. Number the list, starting with 1.
2. Have another individual select a number from 1-175 (the selected number may include 1 and 175). Let's say 40 is selected. Use the selected number 40 as the starting point.
3. Divide the total number of establishments 175 by the sample size 5. [175/5 = 35.] This means that every 35th establishment file will be selected for review.
4. Now find the 40th establishment from the beginning of the list. This is the first file that will be reviewed. Next count forward 35 establishments to find the second file to be reviewed. Continue until five establishment files have been selected. When you reach the end of the list, continue counting from the beginning. You should have selected the following establishments: 40, 75, 110, 145, and 5. Should you need to select more than five, start over with #2 above to avoid selecting items previously selected.

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Annex 6 – Office Sample Size Chart

Determine the number of food establishments licensed, plan reviews conducted, temporary licenses issued, complaints investigated, etc., that a sample is to be drawn from. Find that number under population size, and then find the number of files to be reviewed under sample size.

Population Size	Sample Size (n)*
4	3
5	4
6-7	5
8-9	6
10-13	7
14-16	9
17-19	10
20-23	11
24-27	12
28-32	13
33-39	14
40-47	15
48-58	16
59-73	17
74-94	18
95-129	19
130-192	20
193-340	21
341-1154	22
1155 +	23

Annex 7 – Computer Records

This Annex has been removed for Cycle 5.

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Annex 8 - Accreditation Review Document Summary

The following are the typical documents needed by food service program reviewers that must be available during a review.

MDA Provided Documents

- ❑ Licensed facility list to draw samples from and lists of files randomly selected for review.
- ❑ Log of foodborne illness reports submitted to MDA.
- ❑ Field and office review worksheets.

Local Health Department Provided Documents

- ❑ For Evaluation of Minimum Program Requirements (MPRs)
- ❑ Documentation relating to moot point principle. See MPR Indicator Guide, Cycle 5, Annex 2.
- ❑ Plan Review Log.
- ❑ Plans review files selected for review (all documents and plans relating to review). List of specific files selected will be provided during review.
- ❑ Establishment file for plans selected (pre-opening evaluation and license are needed).
- ❑ Establishment files selected for review (complete and current file, may include, fixed, mobile, STFU, vending, etc.). List of specific files selected will be provided during review.
- ❑ Temporary licenses and evaluations for review period.
- ❑ List of establishments having their licenses limited during review period. Enough information should be on this list to allow these files to be retrieved and reviewed, if requested.
- ❑ List of variances evaluated during review period. Enough information should be on this list to allow these files to be retrieved and reviewed, if requested.
- ❑ Consumer food complaint log and selected complaint files.
- ❑ Foodborne illness complaint log and selected complaint and outbreak investigation files.
- ❑ IAFP 5th edition "Procedures to Investigate Foodborne Illness."
- ❑ Training files for every new employee hired or assigned to the food program since the last accreditation visit. Employees include those who may be occasionally asked to evaluate specialty food service establishments (temporary, STFU, vending, mobile).
- ❑ Policy and procedure documents relating to:
    - o plan review (including forms used)
    - o conducting evaluations and preparing evaluation reports
    - o licensing, including license limitations
    - o enforcement, including documentation of policy adoption (by whom and date adopted)
    - o variances
    - o consumer complaint investigation
    - o foodborne illness complaint and outbreak investigation
    - o vending evaluation frequency

For Evaluation of Important Factors

- ❑ I - Documentation - quality records needed for this standard reflect activities over the most recent three-year period and include:
    - o Minutes, agendas or other records that forums were conducted,

- For formal, recurring meetings, such documents as by- laws, charters, membership criteria and lists, frequency of meetings, roles, etc.,
- Documentation of performed actions or activities designed with input from industry and consumers to improve the control of risk factors, or
- Documentation of food safety educational efforts. Statements of policies and procedures may suffice if activities are continuous, and documenting multiple incidents would be cumbersome, i.e., recognition provided to establishments with exemplary records or an on-going web site.

- ❑ Employee training records.
- ❑ III- Documentation of the total number of FTE's assigned to the food service program.
- ❑ IV- Food service program's quality assurance written procedures.

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Annex 9 – Approximate Review Timeline for a Single Office Agency

USING OPTION 1

Day	Activity	Documents Needed*	Provided By
1	Field Review: Review list of facilities to be visited. Arrange for LHD staff to accompany MDA field reviewer. Office Review: MDA reviewer looks at policies as needed at this point. MDA reviewer draws sample of plan review files to be reviewed. LHD staff pull plans for review. MDA reviewer reviews plans. LHD staff pull establishment files for review. MDA reviewer begins file review if time permits.	List of establishments to be visited. Alternates may be selected if some facilities are closed or not available for a review. Food service policy manual, plus any moot point documentation. Plan review log for review period. Need to be able to determine which reviews were received after beginning of review period and which have been completed through pre-opening evaluation. Plan review documents, including pre-opening evaluation and license application. List of establishment files to be reviewed. Establishment files.	MDA LHD LHD MDA LHD
2	Field: LHD staff accompanies MDA field reviewer. Office: MDA reviewer starts or continues establishment file review. LHD pulls vending establishment files for review. MDA reviewer reviews files.	List of vending establishment files to be reviewed. Vending establishment files.	MDA LHD

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3	Field: LHD staff accompanies MDA field reviewer. LHD staff pull establishment files for facilities visited. MDA reviewer begins file review for establishments visited. Office: MDA reviewer schedules exit interview. LHD staff pulls temporary food services licenses. MDA reviewer selects sample and reviews selected temporary food service files. MDA reviewer selects consumer and foodborne illness complaint sample. LHD staff pull selected consumer and foodborne illness complaint files. MDA reviewer reviews selected consumer and foodborne illness complaint files. MDA reviewer reviews limited licenses and variances, if any for review period. MDA reviewer reviews training documentation for new staff assigned to the food program during the review period.	Establishment files for facilities visited. Temporary food service licenses issued during review period, organized by year. Consumer and foodborne illness complaint logs for review period. Selected consumer and foodborne illness complaint files. Logs for limited licenses and variances. Files containing limited licenses and/or variances for review. Training documentation for new staff. Supervisor endorsement documentation for new staff doing specialty foods.	LHD LHD LHD LHD LHD LHD

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4	Field: MDA reviewer completes file review for establishments visited. Reviewer summarizes results of field evaluation and prepares for exit interview. Office: MDA reviewer reads policies. MDA reviewer reviews documentation relating to important factors and interviews EH director regarding important factor related information. Program managers need to advise MDA reviewer which IF's the agency is not attempting to meet. MDA reviewer summarizes review information and prepares for exit interview.	 Food service policy manual. Documentation showing how agency is meeting important factor standards. See documentation summary, MPR Guidance Document, Annex 8. Copies of various materials made for exit interview. Secretarial assistance usually needed.	LHD LHD

*For a more complete description of documents needed, see, MPR Guidance Document, Annex 8 "Accreditation Review Document Summary."

NOTES: Multiple Offices- When an agency has food program files in multiple offices, all the various records that each office maintains would need to be made available during the visit. For example, during a partial day visit to an office in a district the following types of files are normally reviewed: plans, establishment files, vending files, complaint and foodborne illness files, temporary food service licenses, and employee training records.

The MDA reserves up to five days to conduct each review, in the event additional time is needed due to larger than normal sample sizes or delays. The MDA also increases the number of staff assigned to conduct reviews, if needed, to maintain a particular schedule.

ANNEX 10- ADJUSTMENT OF MPR REVIEW PERIOD

The MDA's intent is to not review the same timeframe twice during different review cycles. Therefore, the review period for specific MPRs will be shortened if:

- That MPR had a follow-up during the previous cycle.
- That follow-up's review time frame overlapped into the next cycle's normal review period.

For example, if the follow-up review for MPR 6 was completed 10 months into the next review period, the on-site initial review will be reduced by 10 months for that specific MPR.

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Annex 11- Cycle 5 Food Program Review Options

Review Options

Compliance with program standards can be demonstrated in one of two ways.

Option 1 - MDA conducts the office and field review to determine compliance with the standards.

Option 2 - The local health department demonstrates how the agency is in compliance to the MDA auditor.

Option 2 Review Elements

The review shall consist of the following elements:

- Oral presentation / discussion outlining the food safety program's ongoing.
  a. quality assurance activities
  b. self-assessment against established program standards
- Self-assessment document review presented to the auditor by the agency staff to verify that the self-assessment was completed accurately and properly. Field assessment is demonstrated by the local health department's quality assurance program and will be reviewed by the auditors.
  a. The agency will receive the rating it gave itself on any MPRs, providing the audit verifies the rating as correct. Should an agency assess any indicator as:
     1. Not met or met with conditions.
     2. Puts a corrective action plan in place.
     3. Shows 90 days compliance with that plan by conducting another self-assessment of that indicator.
     4. Then the agency shall receive a met or met with conditions on that MPR.
  a. Should the self-assessment show an incorrect rating or a program element that was not properly or completely reviewed, that element shall be jointly reviewed with the MDA auditor and local health department staff to determine the correct rating.
  b. The auditor may review a number of the original documents assessed to determine if the self-assessment is correct and accurate.
- Field demonstration in agency-selected food establishments of the department's risk-based evaluation processes.
  a. The field demonstration shall consist of visiting food establishments of varying risk levels, providing 50% of the establishments visited are at the highest risk level.

# Inspectors per agency	Minimum # establishments visits per agency
1-4	2
5-10	4
11+	6

- Number of visits may be increased upon joint agreement between the auditor and the local health department management that an increased number of visits would provide a more accurate assessment. The MDA auditor may allow staff to conduct a practice evaluation, as time and need allows.
  a. Show demonstration of risk-based evaluations by a variety of program staff. When possible, each establishment visit must be with a different inspector. A maximum of one standardized trainer who is currently conducting routine inspections may be used.
  b. Demonstrate that risk factors present in the establishment are correctly identified.

c. Demonstrate how the presence of those risk factors is communicated orally and in writing to the establishment and resolved.
d. MPRs 7 and 8: The rating determination shall be based upon:
   1. The oral discussion of field quality assurance activities.
   2. A review of the written quality assurance documentation, including frequency and use of risk based methodology. A field exercise demonstrating that food program inspectors are properly utilizing a risk–based evaluation methodology using the Field Evaluation Worksheet.

How to Judge Compliance with MPRs 7 and 8 Using Review Option 2

- **Met** - Both of the following are done:
- Staff quality assurance field reviews are being conducted at a frequency in accordance Important Factor IV.
- Field exercise demonstrates that food program inspectors are properly utilizing a risk-based evaluation methodology.
- **Met with Conditions** - The conditions for a met are generally achieved; however, the field quality assurance frequency is below the standards and/or the field demonstration shows a moderate number of problems.
- **Not Met** - Field quality assurance reviews are not being done and/or significant problems were documented during the field demonstration.

Tips for Passing MPR's 7 and 8 Using Review Option 2

- Formally standardize evaluation staff.
- Agencies having only one food inspector should use a standardized trainer from another agency to conduct field quality assurance reviews.

The MDA may conduct additional surveys in agency regulated food establishments during the visit for statewide, risk-reduction survey purposes. These evaluations will not be used to determine whether any MPRs are met or not met. Results of these visits will be provided to the agency for consultative purposes.

Criteria to Qualify for Option 2

All local health departments are encouraged to utilize this review option. However, an agency best prepared to use this option has adequate program resources and is conducting thorough quality assurance program reviews. Agencies meeting all elements of part A and 80% of the elements of part B are automatically approved to use Option 2. Should an agency not meet the automatic approval criteria, the application must be submitted to the MDARD at least one year prior to their on-site visit for a case-by-case review.

Quality assurance may be accomplished through an agency specific plan, designed to meet agency needs. However, during the oral phase of the evaluation, the agency must be prepared to discuss the specific, substantive activities being carried out.

Part A:

- For automatic approval to use review Option 2, meet 100% of the following:
  a. Meet 90% of the food program MPRs during the agency's last accreditation review.
  b. Complete one or more documented program self-assessments covering the following time period:
     1. For agencies that did not use Option 2 during their previous review:

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a. Complete one or more self-assessments covering the first two years of the current review period (two-year total).
b. Example: On-site review is scheduled for March 2011. Normal review period is March 2008-March 2011. Assessment(s) must be completed around March 2010 and cover March 2008-March 2010.

2. For agencies that used Option 2 during their previous review:
   a. Complete one or more self-assessments covering the last year of the previous review period and the first two years of the current review period (three years total).
   b. Example: On-site review is scheduled for March 2012. Normal review period is March 2009-March 2012. Assessment(s) must be completed around March 2011 and cover March 2008-March 2011.
3. Self-assessments must be completed approximately 12 months before the scheduled review date. This review shall be completed using the MDA Self-Assessment Guide (MPRs 7 and 8 do not need to be reviewed).
4. Conduct quality assurance reviews of existing staff in field. (i.e. see Important Factor 4).

Part B:

- For automatic approval to use review Option 2, meet 80% of the following applicable criteria (i.e.18 of 22, 17 of 21, 16 of 20, etc.). Only item numbers 15,16,18,19, and 20 may be considered not applicable due to their being no activity in that program area during the review period.

Program Advancement	
	1. Maintain at least one food program staff member that is MDA standardized.
	2. Enroll in FDA Voluntary Retail Standards
	3. Maintain a tracking system to monitor risk factor occurrence in establishments; compare with state risk-reduction surveys and local historical records for the purpose of program improvement.
	4. Regularly utilize and document use of long-term control measures (i.e. such as risk control plans) with food establishments to assist in obtaining long-term compliance.
Plan Review	
	5. Conduct ongoing quality assurance on the following program area: **Plan reviews properly conducted and documented.**
	6. Conduct ongoing quality assurance on the following program area: **Pre-opening evaluations properly conducted and documented.**
	7. Conduct ongoing quality assurance on the following program area: **Unauthorized construction recognized and controlled.**
Evaluations	
	8. Conduct ongoing quality assurance on the following program area: **Evaluation frequency meets required schedules.**
	9. Conduct ongoing quality assurance on the following program area: **Follow-up evaluations meet required schedules.**
	10. Conduct ongoing quality assurance on the following program area: **Evaluation procedures meet MPR 6 requirements.**
	11. Conduct ongoing quality assurance on the following program area: **Vending machine location evaluations meet required schedules.**
	12. Conduct ongoing quality assurance on the following program area: **Temporary**

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	food service establishment evaluations properly conducted and documented.
	13. Conduct ongoing quality assurance on the following program area: **Enforcement conducted per department policy.**
Miscellaneous	
	14. Conduct ongoing quality assurance on the following program area: **Records properly maintained and filed.**
	15. Conduct ongoing quality assurance on the following program area: **License limitations issued and documented per law.**
	16. Conduct ongoing quality assurance on the following program area: **Variances issued and documented per law.**
	17. Conduct ongoing quality assurance on the following program area: **Consumer complaint investigations (nonillness) properly conducted and documented.**
Training	
	18. Conduct ongoing quality assurance on the following program area: **Technical training for staff conducted per MPR 16 requirements.**
	19. Conduct ongoing quality assurance on the following program area: **Fixed food service evaluation skills for staff conducted per MPR 17 requirements.**
	20. Conduct ongoing quality assurance on the following program area: **Specialty food service evaluation skills conducted per MPR 18 requirements.**
Foodborne Illness	
	21. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigation conducted per MPR 19 requirements.**
	22. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigations conducted per MPR 20 requirements.**

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Annex 12 – Cycle 5
Accreditation Review Option 2 Application

E-mail completed application to: dunleavys@michigan.gov when you have completed your self-assessment process. The self-assessment should be completed 1 year before the agency's scheduled accreditation visit.

Agency Name:
Application completed by (name and title):
Phone:
E-Mail:
Date completed:

Our agency wishes to use review option 2 for our upcoming accreditation review.

Criteria to qualify for option 2:
All LHD's are encouraged to utilize this review option. However, an agency best prepared to use this option is conducting thorough quality assurance program reviews. Agencies meeting all elements of part A and 80% of the elements of part B are automatically approved to use option 2.

Should an agency not meet the automatic approval criteria, the application must be submitted to MDA at least one year prior to their on-site visit for a case-by-case review.

Quality assurance may be accomplished through an agency specific plan, designed to meet agency needs. However, during the oral phase of the evaluation, the agency must be prepared to discuss the specific, substantive activities being carried out.

Part A: Mark all items as Met, Not Met (NM) or Not Applicable (NA).

MET NM	Meet 90% of the food program MPRs during the agency's last accreditation review.
MET Date(s) completed: _____ NM	Complete a documented program self-assessment covering the normal accreditation review period 12 months before the scheduled review date (time may be shortened during for some agencies during initial implementation period). This review shall be completed using the MDA Self-Assessment Guide (MPR's 7&8 do not need to be reviewed).
MET NM	Conduct quality assurance reviews of existing staff in field (i.e. FDA Voluntary Retail Standard 2 or Important Factor IV contain quality assurance guides).

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Part B: Mark all items as Met, Not Met (NM) or Not Applicable (NA).

For automatic approval to use review option 2 meet 80% of the following applicable criteria (i.e.18 of 22, 17 of 21, 16 of 20, etc.). Only item numbers 15,16,18,19 and 20 may be considered not applicable due to their being no activity in that program area during the review period.

Program Advancement	
MET NM	1. Maintain at least one food program agency staff member that is MDA standardized.
MET NM	2. Enroll in FDA Voluntary Retail Standards
MET NM	3. Maintain a tracking system to monitor risk factor occurrence in establishments, compare with state risk-reduction surveys and local historical records for the purpose of program improvement.
MET NM	4. Regularly utilize and document use of long term control measures (i.e. such as risk control plans) with food establishments to assist in obtaining long term compliance.
Plan Review	
MET NM	5. Conduct ongoing quality assurance on the following program area: **Plan reviews properly conducted and documented**
MET NM	6. Conduct ongoing quality assurance on the following program area: **Pre-opening evaluations properly conducted and documented**
MET NM	7. Conduct ongoing quality assurance on the following program area: **Unauthorized construction recognized and controlled**
Evaluations	
MET NM	8. Conduct ongoing quality assurance on the following program area: **Evaluation frequency meets required schedules**
MET NM	9. Conduct ongoing quality assurance on the following program area: **Follow-up evaluations meet required schedules**
MET NM	10. Conduct ongoing quality assurance on the following program area: **Evaluation procedures meet MPR 6 requirements**
MET NM	11. Conduct ongoing quality assurance on the following program area: **Vending machine location evaluations meet required schedules**
MET NM	12. Conduct ongoing quality assurance on the following program area: **Temporary food service establishment evaluations properly conducted and documented**
MET NM	13. Conduct ongoing quality assurance on the following program area: **Enforcement conducted per department policy**
Miscellaneous	
MET NM	14. Conduct ongoing quality assurance on the following program area: **Records properly maintained and filed**
MET NM NA	15. Conduct ongoing quality assurance on the following program area: **License limitations issued and documented per law**
MET	16. Conduct ongoing quality assurance on the following program area:

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NM NA	**Variances issued and documented per law**
MET NM	17. Conduct ongoing quality assurance on the following program area: **Consumer complaint investigations (non-illness) properly conducted and documented**
Training	
MET NM NA	18. Conduct ongoing quality assurance on the following program area: **Technical training for staff conducted per MPR 16 requirements**
MET NM NA	19. Conduct ongoing quality assurance on the following program area: **Fixed food service evaluation skills for staff conducted per MPR 17 requirements**
MET NM NA	20. Conduct ongoing quality assurance on the following program area: **Specialty food service evaluation skills conducted per MPR 18 requirements**
Foodborne Illness	
MET NM	21. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigation conducted per MPR 19 requirements**
MET NM	22. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigations conducted per MPR 20 requirements**

Agency Comments (Additional brief documents may be attached, if desired):

Annex 13- Report Marking Instructions for Option 2 Field Evaluation Worksheets (2005 Food Code, Annex 5, Part 4 (A-H) References)

Review

The accreditation process for field evaluations for Cycle 5, Option 2, will be based on the local health department evaluator's knowledge, skills, and abilities; not on the condition of the food service establishment. The Field Evaluation Worksheet, in combination with a review of existing quality assurance documentation, will be used to judge MPRs 7 and 8. For this document, the evaluator is the local health department, food service inspector; and the auditor is the MDA, food service specialist conducting the accreditation.

The evaluator must demonstrate knowledge of foodborne illness risk factors and interventions along with good retail practices (GRPs).

Communication

The Field Evaluation Worksheet along with the risk-based inspection process evaluated during Cycle 5 Accreditation, Option 2, stresses open communication between the evaluator and operator. To be an effective communicator, the evaluator is expected to ask questions relative to the flow of food through the establishment, preparation and cooking procedures, employee health, and normal everyday operation of the facility (i.e., GRPs). Response statements made by the person in charge (PIC) or food employees should be used to support or augment direct observations. When observations are made while a food is undergoing a process (i.e., cooling and reheating), the evaluator should ask the PIC or food employees questions to support the actual observations and determine Food Code/Food Law compliance.

Option 2 field exercises focus on an audit of the evaluator, not the establishment.
There are some differences in the accreditation process when choosing Option 2 that must be discussed and understood, prior to the accreditation exercise, by the auditor and the evaluator. These include the following:

- There will be no interaction, guidance or training from the MDA auditor to the food service evaluator during the audit. It is expected that the evaluator will verbally address all findings of either compliance or noncompliance throughout the entire accreditation exercise. **Communication** is the only way for the auditor to know what the evaluator is seeing, and how compliance is determined.
- At the end of the accreditation exercise the evaluator will be given time to look over their notes, check sheets, or any other guidance form that they use for the evaluation to ensure they have completed the inspection. Any additional information obtained by the evaluator, prior to leaving the facility, may be communicated to the auditor.
- Once the auditor and evaluator leave the facility, the accreditation exercise is over. No changes may be made to the auditor's report.
- To maintain consistency throughout the process, there will be no feedback given from the auditor to the evaluator after the accreditation exercise. On the same note, there will be no feedback given from the auditor to the Environmental Health Director or Food Supervisor until all accreditation exercises are complete, and compliance with MPR 7 and 8 is determined.

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GUIDELINES FOR DETERMINING EVALUATOR COMPETENCY

YES/NO
Due to the nature of the accreditation exercise, the evaluator is being reviewed, not the establishment or PIC. The evaluator's knowledge is demonstrated by both direct observations and supportive questioning.

- To mark a YES under Competency Demonstrated:
  a. The evaluator must verify risk factors, interventions, and GRPs not only by observation, but also through questions asked about procedures, practices, and monitoring.
- A Competency Demonstrated will be marked as NO if:
  a. An observation is missed by the evaluator (i.e., no cooking temperatures were taken of food cooked and served during the accreditation exercise).
  b. The procedure is not being performed at the time of the evaluation and no line of
  c. questioning is conducted to determine compliance (i.e., reheating is performed by the food service establishment but not during the evaluation and questions on procedures for reheating are not asked by the evaluator).
  d. The procedure is being performed at time of the evaluation and observed as a possible violation, but the candidate does not determine the root cause in order to verify which Food Code section to cite.

No Opportunity to Demonstrate Competency
No opportunity to demonstrate competency during the accreditation process will only be marked if the establishment never performs the procedure or process. For instance, if the food service establishment is only a cook-serve establishment, processes such as hot-holding, cooling, and reheating for hot-holding are not performed; therefore, these items would be marked as No Opportunity to Demonstrate Competency.

Field Evaluation Worksheet Competency Guidelines
The following guidance may be used to determine the evaluator's competency in each of the categories listed below.

II. Inspections, Observations, and Performance

(C) Risk Based Inspection/Active Managerial Control

1. **Verified demonstration of knowledge of the person in charge.**
   - For the evaluator to be marked YES in this category the following items must be evaluated:
     a. PIC present.
   - Determine presence of PIC:
     a. the person responsible for monitoring and managing shall be immediately available and knowledgeable in operational procedures and Food Code/Food Law requirements.
     b. Demonstration of knowledge.
   - Determine that the PIC meets at least one of these three criteria:
     a. Certification by an ACCREDITED PROGRAM per §2-102.20.
     b. Compliance with the Code and Law by having no violations of critical items during the current inspection.

c. Correct responses to the inspector's questions regarding public health practices and principles applicable to the operation.

NOTE: In lieu of a certification, the evaluator should assess the PIC's knowledge by asking open-ended questions that would evaluate the PIC's knowledge in each of the areas enumerated in §2-102.11(C). Questions can be asked during the initial interview, menu review, or throughout the inspection as appropriate. The evaluator should ask a sufficient number of questions to enable the evaluator to make an informed decision concerning the PIC's knowledge of the code requirements and public health principles as they apply to the operation.

- PIC duties.
  a. Determine if the PIC is ensuring that employees are complying with the duties listed in §2-103.11.

NOTE: Since marking this item out of compliance requires judgment by the evaluator, it is important that this item not be marked for an isolated incident, but rather for an overall evaluation of the PIC's ability to ensure compliance with the duties described in §2-103.11.

2. Verified the restriction or exclusion of ill employees.

- In order for the evaluator to be marked YES in this category the following items must be evaluated: Whether or not the PIC…
  a. Is aware of the requirement for employees to report specific symptoms and diagnosed illnesses, and knows what the symptoms and illnesses are (i.e., having it posted-§2-201.11).
  b. Can convey knowledge of an employee health policy or have access to an employee health policy (written not required), and identify what actions are necessary when an employee does report symptom or diagnosed illness, (§2-201.12).
  c. Is aware of requirements covering an employee returning to work (§2-201.13).

NOTE: The policy must reflect the current Food Code provisions. Verbal communication of the employee health policy must be specific to the types of illnesses and symptoms that require reporting. Nonspecific statements such as "sick or ill employees are not allowed to work," do not fully address the employee illness requirements of §2-201.12. Further questioning would be warranted.

3. Verified the availability of a consumer advisory for foods of animal origin served raw or undercooked.

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Determine whether raw or undercooked foods are served or sold routinely or seasonally.
  b. Determine that a consumer advisory with a disclosure and reminder is present as specified under § 3-603.11 of the Food Code or as stated in the Michigan Food Law 2000, as amended.

4. Verified approved food sources (e.g., food from regulated food processing plants; shellfish documentation; wild game and mushrooms, game animal processing; parasite destruction for certain species of fish intended for raw consumption; receiving temperatures).

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. All foods are from a regulated food processing plant or other approved source (no home prepared items).

b. Foods are received at proper temperatures, protected from contamination during transportation, and received safe and unadulterated.
c. Determine if any specialty food items are served or specialty processing is done (i.e., wild game or mushrooms, game animal processing, and parasite destruction).

NOTE: Include questions on segregation of distressed products, temperature monitoring, and how receiving procedures meet Food Code requirements.

5. **Verified cooking temperatures to destroy bacteria and parasites.**
   - In order for the evaluator to be marked YES in this category the following items must be evaluated:
     a. Every effort should be made to assess the cooking temperatures of a variety of products served in the food establishment.
     b. Determine if PIC and employees know and are following proper cooking time and temperature parameters (include microwave cooking requirements).
     c. The presence of required thermometers and their proper use should be assessed.

NOTE: The evaluator should involve the PIC and/or employees in this verification process in order to determine compliance with cooking time/temperature requirements (i.e., having the PIC take the temperatures). Observations need to be supported by proper questioning.

6. **Verified reheating temperatures of TCS food for hot holding.**
   - In order for the evaluator to be marked YES in this category the following items must be evaluated:
     a. Which foods are reheated for hot holding.
     b. How reheating is done (include reheating in microwave) and if employee and PIC are knowledgeable of required parameters.
     c. Temperature of foods being reheated when possible.

NOTE: If items are found "reheating" on the steam table, further inquiry is needed to assess whether the equipment in question is capable of reheating the food to the proper temperature within the maximum time limit. If an operation does not reheat for hot holding, then this category would be marked as No Opportunity to Demonstrate Competency.

7. **Verified cooling temperatures of TCS food to prevent the outgrowth of spore-forming or toxin-forming bacteria.**
   - In order for the evaluator to be marked YES in this category the following items must be evaluated:
     a. Determine types of foods that are cooled.
     b. Determine procedures for meeting required cooling parameters.
     c. Determine if procedures are being followed (i.e., methods and monitoring) and employee's and PIC's knowledge of cooling requirements.
     d. Verify food temperatures when possible.

NOTE: Problems with cooling can often be discovered through inquiry alone. Even when no cooling is taking place, inspectors should ask food employees and managers questions about the cooling procedures in place. Due to the time parameters involved in cooling, inspectors should always inquire at the beginning of the inspection if there are any products currently being cooled. This provides an opportunity to take initial temperatures of the products and still have time to recheck temperatures later in the inspection in order to

verify that critical limits are being met. Information gained from food employees and management, in combination with temperature measurements taken, should form the basis for assessing compliance of cooling during an inspection.

8. **Verified cold holding temperatures of foods requiring time/temperature control for safety (TCS food), or when necessary, verified that procedures are in place to use time alone to control bacterial growth and toxin production.**
   - In order for the evaluator to be marked YES in this category the following items must be evaluated:
     a. Determine compliance by taking food temperatures in multiple cold holding units.
     b. Evaluate operational procedures that are in place to maintain cold holding requirements (i.e., monitoring of food temperatures, and the ambient temperatures of equipment, by the operator).
     c. If time alone is used, review written policy and determine that policy meets requirements of the Food Code and is being followed.

9. **Verified hot holding temperatures of TCS food or when necessary, that procedures were in place to use time alone to prevent the outgrowth of spore-forming bacteria.**
   a. In order for the evaluator to be marked YES in this category the following items must be evaluated:
      a. Determine compliance by taking food temperatures in multiple hot holding units.
      b. Evaluate operational procedures that are in place to maintain hot holding requirements (i.e., monitoring of food temperatures, and the ambient temperatures of equipment, by the operator).
      c. If time alone is used, review written policy, determine that policy meets requirements, and is being followed.

10. **Verified date marking of ready-to-eat foods TCS food held for more than 24 hours.**
    - In order for the evaluator to be marked YES in this category the following items must be evaluated:
      a. Determine those foods requiring date marking.
      b. Evaluate whether the system in place to control for L. monocytogenes meets the intent of the Food Code and is being followed.

NOTE: With exceptions, all ready-to-eat, potentially hazardous foods (TCS foods) prepared on-site and held for more than 24 hours should be date marked to indicate the day or date by which the food need to be served or discarded.

11. **Verified food safety practices for preventing cross-contamination of ready-to-eat food.**
    - In order for the evaluator to be marked YES in this category the following items must be evaluated:
      a. Determine proper separation of raw animal foods and ready-to-eat foods from each other by cooking temperature.
      b. Evaluate practices to eliminate the potential for contamination of utensils, equipment, and single-service items by environmental contaminants, employees, and consumers.
      c. Evaluate food storage areas for proper storage, separation, segregation, and protection from contamination.

12. **Verified food contact surfaces are clean and sanitized, protected from contamination from soiled cutting boards, utensils, aprons, etc., or raw animal foods.**

Section II: Food Service

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate food-contact surfaces of equipment and utensils to verify that these are maintained, cleaned, and sanitized.
  b. Assess how utensils and cookware are washed, rinsed, and sanitized.
  c. Evaluate type of sanitizer, concentration, proper use, and use of chemical test strips.

13. Verified employee hand washing (including facility availability).

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate proper hand washing method, including appropriate times.
  b. Evaluate location, accessibility, and cleanliness of hand wash sinks.

14. Verified good hygienic practices (i.e., eating, drinking, tasting, sneezing, coughing, or runny nose; no work with food/utensils).

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate policy for handling employees with sneezing, coughing, or runny nose.
  b. Evaluate availability and use of employee break area (where employees eat, drink, or smoke).
  c. Evaluate use of hair restraints.

15. Verified no bare hand contact with ready-to-eat foods (or use of a pre-approved, alternative procedure).

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate operation's policy for handling ready-to-eat foods.
  b. Evaluate employee practices of handling ready-to-eat foods.
  c. Evaluate alternative procedure for bare hand contact if applicable (i.e., review policy, question employees about the use of the policy, and determine proper use of policy).

16. Verified proper use, storage, and labeling of chemicals; sulfites.

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate proper storage and labeling of chemicals.
  b. Evaluate if chemicals are approved for use in food establishment (include drying agents, veggie/fruit chemical wash, food coloring, sulfite agents, insecticides, and pesticides).
  c. Evaluate proper use of chemicals.

17. Identified food processes and/or procedures that require an HACCP Plan per the jurisdiction's regulations.

- In order for the evaluator to be marked YES in this category the following items must be evaluated:
  a. Determine if any process or procedure requires a HACCP plan.
  b. Review the written HACCP policy (as stated in the Food Code §8-201.14).
  c. Evaluate appropriateness, effectiveness, and implementation of the plan.

Section II: Food Service

(E) Good Retail Practices

GRPs are the foundation of a successful food safety management system. GRPs found to be out-of-compliance may give rise to conditions that may lead to foodborne illness (e.g., sewage backing up in the kitchen). To effectively demonstrate knowledge of certain risk factors, the evaluator must also address related GRPs (i.e., when evaluating if food contact surfaces are clean and sanitized, test kits would be part of the assessment of the ware washing process).

The evaluator is being audited on their overall assessment of GRPs by using observations and/or questions.

- In order for the Evaluator to be marked YES in this category the following items must be evaluated:
  a. Evaluate the protection of products from contamination by biological, chemical, and physical food safety hazards.
  b. Evaluate control of bacterial growth that can result from temperature abuse during storage.
  c. Evaluate the maintenance of equipment, especially equipment used to maintain product temperatures.

NOTE: Examples of concerns addressed by the basic operation and sanitation programs include the following:

- Pest control
- Food protection (non-critical)
- Equipment maintenance
- Water
- Plumbing
- Toilet facilities
- Sewage
- Garbage and refuse disposal
- Physical facilities
- Personnel

Section III: General Communicable Disease Control

MPR 1

The local health department must have a system in place that allows for the referral of disease incidence and reporting information from physicians, laboratories, and other reporting entities to the local health department.

References: **Michigan Administrative Code R 325.174 (1) (5); R325.173 (7).*

Indicator 1.1

The local health department shall maintain annually reviewed policies and procedures.

This indicator may be met by:

- Maintaining the following policies and procedures for:
    - Receiving case reports from citizens, physicians, health care facilities, laboratories, and other reporting entities;
    - Entering the received reports into the MDSS;
    - Timely submission of case reports via the MDSS to MDCH;
    - Completion of case reports;
    - How and when data is collected, collated, and analyzed and who within the local health department is responsible for such activities; **AND**
- Evidence that policies and procedures are reviewed annually.

Documentation Required:

- Providing the above policies and procedures.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following individuals: CD/Nursing Supervisor, Medical Director, or Health Officer.

Evaluation Question:

None

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

Indicator 1.2

The local health department collects, collates, and analyzes communicable disease surveillance data that is reported to their jurisdiction by physicians, laboratories, and other authorized reporting entities.

This indicator may be met by:

- The local health department conducts weekly analysis of reported disease cases that shall be documented in a log (e.g., weekly MDSS line list, report, or hand-written log) and signed-off by the CD/Nursing Supervisor, Epidemiologist, or Medical Director.
- Weekly Surveillance log (e.g., weekly MDSS line list, report, or hand-written log of cases).

Documentation Required:

Evidence that weekly surveillance log is monitored and signed-off on a weekly basis by the CD/Nursing Supervisor, Epidemiologist, or Medical Director.

Evaluation Question:

None

Indicator 1.3

The local health department electronically submits communicable disease cases and case report forms (PDF forms) that are complete, accurate, and timely to MDCH by utilization of the Michigan Disease Surveillance System (MDSS).

Note: A random sample of case reports will be pulled out of MDSS by the reviewer prior to the on-site visit for evaluation of this indicator.

This indicator may be met by:

- Evidence of MDSS and case report form utilization; **AND**
- Entry within 1 business day of received communicable disease reports into the MDSS; **AND**
- Within 7 days of receipt, at least 90% of case demographic data (name, address, age/date of birth, sex, race, ethnicity, and disease) is completed in MDSS; **AND**

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

- Upon case completion, at least 90% of the detailed case report (PDF) form's available fields are accounted for/filled in/completed. Information that cannot be obtained should be documented. To meet this indicator, 90% of the cases pulled by the reviewer (18/20) will have to meet the above criteria; **AND**

- Cases are updated, reactivated, and/or reclassified in MDSS as new information is obtained (e.g., laboratory serogroups and serotype results, patient outcome, and outbreak identification).

Documentation Required:

- Documentation indicating the staff responsible for MDSS case entry.

- Evidence of case completion efforts, reporting timeline requirements, and staff instructions to update case report forms in MDSS as new information is obtained.

Evaluation Question:

None

Indicator 1.4

The local health department shall create an annual report (or formal summary) that includes aggregate communicable disease data for dissemination throughout the local health department's jurisdiction.

This indicator may be met by:

- The local health department maintains and displays communicable disease case counts in an annual report that can be distributed to interested entities such as community physicians, infection control, and private citizens. The annual report (or formal summary) should include aggregate data for the previous three years to illustrate the jurisdiction's communicable disease trends.

- **(Special Recognition)** The local health department may also disseminate a quarterly update with similar data to the above groups of people.

Documentation Required:

- Annual report (or formal summary) for the past 3 years (paper copy or electronic/web-based equivalent).

- List of stakeholders who receive Annual Report/quarterly updates.

Documentation Requested:

(Special Recognition) Quarterly updates or other news bulletins that get disseminated through the LHD jurisdiction.

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

MPR 2

The local health department shall perform investigations of communicable diseases as required by Michigan law.

References: *PA 368 of 1978, MCL 333.2433 (2)(a)(c)(i)(iii); Michigan Administrative Code R 325.174 (1) (5); R 325.173 (7).*

Indicator 2.1

The local health department shall maintain annually reviewed policies and procedures.

This indicator may be met by:

- Maintaining the following policies and procedures for:
    - Investigating individual case reports;
    - Initiation of outbreak investigations;
    - Specific reportable diseases; **AND**
- Evidence that policies and procedures are reviewed annually.

Documentation Required:

- Providing the above policies and procedures.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following individuals: CD/Nursing Supervisor, Medical Director, or Health Officer.

Evaluation Question:

None

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

Indicator 2.2

The local health department shall initiate communicable disease investigations as required by Michigan laws, rules, and/or executive orders.

This indicator may be met by:

- The LHD investigates individual case reports; **AND**
- The LHD conducts investigations of communicable disease outbreaks and clusters; **AND**
- The LHD maintains protocols of specific communicable diseases that are required to be reported by Michigan laws or rules.

Documentation Required:

- Documents and/or records that illustrate how the LHD investigates individual case reports received. This includes identifying who initiates the investigation, what action shall be taken, and the appropriate timelines to be followed.
- Documents and/or records that illustrate how the LHD conducts investigations of communicable disease outbreaks and clusters. This should include identification of roles, corresponding responsibilities during an outbreak, and communication with MDCH Communicable Disease personnel.
- Documents and/or records that illustrate the use of disease specific protocols.

Evaluation Question:

None

Indicator 2.3

The local health department shall notify MDCH immediately of a suspected communicable disease outbreak in their jurisdiction.

This indicator may be met by:

- The local health department notifies MDCH within 24 hours when their jurisdiction suspects a communicable disease outbreak. Notification can be via phone, fax, MDSS (must include outbreak identifier), or Notification of Serious Communicable Disease form; **AND**
- The local health department has a protocol that declares who at the local health department notifies MDCH and what specific information should be relayed (e.g., possible pathogen, source, number ill, facility); **AND**

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Section III: General Communicable Disease Control

- The local health department maintains a file of outbreaks investigated in their jurisdiction. This review will exclude isolated complaints on the EH foodborne illness complaint log. However, reports (6-point narratives) from outbreaks that are co-investigated by both EH and CD will need to be copied and brought to this review, as epidemiological components of the outbreak will be reviewed.

Documentation Required:

- LHD chosen means for MDCH notification.
- Protocol for notifying MDCH.
- Outbreak investigation folder.

Evaluation Question:

None

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

MPR 3

The local health department shall enforce Michigan law governing the control of communicable disease as required by administrative rule and statute.

References: *PA 368 of 1978, MCL § 333.2433(1)(2); MCL § 333.2451(1); *Michigan Administrative Code R 325.174 (1) (5).*

Indicator 3.1

The local health department shall maintain annually reviewed policies and procedures.

This indicator may be met by:

- Maintaining the following policies and procedures:
    - Case follow-up and completion;
    - Guidance to prevent disease transmission; **AND**
- Evidence that policies and procedures are reviewed annually.

Documentation Required:

- Providing the above policies and procedures.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following individuals: CD/Nursing Supervisor, Medical Director, or Health Officer.

Evaluation Question:

None

Indicator 3.2

The local health department performs activities necessary for case follow-up, which includes guidance to prevent disease transmission.

This indicator may be met by:

- The LHD can demonstrate timely case follow-up, follow-up efforts, and completion/updates of cases in MDSS; **AND**
- The LHD maintains control guidelines or other guidance materials to assist in the control of disease spread (e.g., Norovirus Control Guidelines in Nursing Homes, etc.) that can be distributed to community partners; **OR**

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section III: General Communicable Disease Control

- Additional educational materials, fact sheets, or other guidance documents that will assist the LHD with prevention of disease transmission.

- **(Special Recognition)** Provide communicable disease presentations to educational venues such as conferences and community health education fairs.

Documentation Required:

Records and/or documentation that demonstrates timely case follow-up, follow-up efforts, and completion/updates of cases in MDSS.

Documentation Requested:

- Control guidelines or other guidance materials to assist in the control of disease spread (e.g., Norovirus Control Guidelines in Nursing Homes, etc.) that can be distributed to community partners.

- Additional educational materials, fact sheets, or other guidance documents that will assist the LHD with prevention of disease transmission.

- **(Special Recognition)** Communicable disease presentations to educational venues such as conferences and community health education fairs.

Evaluation Question:

None

Indicator 3.3

Presence of adequately prepared staff capable of enforcing Michigan law governing the control of communicable diseases.

This indicator may be met by:

- Staff has access to current and up-to-date reference materials (e.g., Control of Communicable Diseases Manual; Red Book; Brick Book; Michigan Communicable Disease Handbook; CDC Core Curriculum on Tuberculosis; MMWR case definitions; FIRST, Rabies, Head lice, and Scabies manuals, etc.); **AND**

- Attendance of professional development activities (which may offer CME, CEU, or contact hours), which may include in-services, conferences, seminars, and trainings.

Documentation Required:

- LHD has documentation of CD staff participation in professional development activities, conferences, seminars, and/or trainings.

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Section III: General Communicable Disease Control

- The documentation for the above indicator may include either a copy of the CEU certificate or a listing of activities attended for a given year, along with the date of the activity.

Evaluation Question:

None

Indicator 3.4

The local health department shall complete and submit the necessary foodborne or waterborne outbreak investigation forms.

This indicator may be met by:

For foodborne outbreaks, the local health department completes and submits the CDC 52.13 (foodborne) outbreak form to MDCH and the Michigan Department of Agriculture and Rural Development (MDARD) within 60 days of the date the first case became ill.

For waterborne outbreaks, the local health department completes and submits the CDC 52.12 (waterborne) outbreak form to MDCH within 60 days of the date the first case became ill.

In the event that an investigation is still ongoing 60 days post first illness onset date, a preliminary 52.12 or 52.13 report (which includes data such as county of outbreak, onset date, exposure date, number of cases, and laboratory results) must be submitted to MDCH within 60 days of the date the first case became ill; the completed final outbreak report form must then be sent to the appropriate agency(s) within 90 days.

Documentation Required:

Copies of completed CDC 52.13 and CDC 52.12 forms

Evaluation Question:

None

For technical assistance, please contact Shannon Andrews Johnson (andrewssh@michigan.gov) at 517-335-9567 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690 or Erin Crandell-Alden (crandelle@michigan.gov) at 517-335-9464

Section IV: Hearing

MPR 1

The local health department shall make available hearing screening for preschool children between the ages of 3 and 5 years.

Reference: *Michigan Administrative Code, R 325.3274(1).*

Indicator 1.1

There is a system in place to schedule children between the ages of three and five years for hearing screening upon request.

This indicator may be met by:

- A written policy or program plan articulating procedures for hearing screening for children between the ages of three and five years; **AND**
- An annual timetable for the purpose of notifying the public of hearing screening dates, locations, and procedures for scheduling preschool children ages three to five;

Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.2

Documentation of hearing screening is on file for children between the ages of three and five years.

This indicator may be met by:

- Individual client screening forms and an appointment book or agency calendar documenting hearing technician assignments and/or responsibilities for the past year showing preschool children who were scheduled and received hearing screening services; **AND**
- A list of names and referral forms for preschool children who were referred for further evaluation; **AND**
- A list of Head Start and child-care centers scheduled to receive hearing screening services for the current year, unless these populations are screened through EPSDT.
- The local health department quarterly statistical records indicating the number of preschool age children screened for the past year.

Documentation Required:

For technical assistance, please contact Jennifer Dakers at 517-335-8353 or dakersj@michigan.gov

Section IV: Hearing

See above.

Evaluation Question:

None

Section IV: Hearing

MPR 2

The local health department shall assure that school-age children receive hearing screening every other year through grade 4.

Reference: *Michigan Administrative Code, R 325.3274(2).*

Indicator 2.1

Program activity reports and statistics document the provision of hearing screening in all private and public (including charter) schools for all estimated children in need (e.g., total number of children in grades K, 2, and 4).

This indicator may be met by:

- A chart or schedule documenting agency hearing technician assignments and/or responsibilities for the current year; **AND**
- A written policy or program plan articulating the level of frequency for hearing screening for school-age children; **AND**
- A composite list of names of school-age children who were screened and referred for the past year; **AND**
- The local health department quarterly statistical records indicating the number of school-age children screened for the past year.

Documentation Required:

See above.

Evaluation Question:

None

Section IV: Hearing

MPR 3

The local health department shall assure that hearing screening is conducted in accordance with the MDCH Hearing Technician's Manual (DCH0519B, Rev. 6/03).

References: *Michigan Administrative Code, R 325.3272; R 325.3273.*

Indicator 3.1

All Stage I hearing screening is conducted individually with a pure tone audiometer at the frequencies of 1000, 2000, and 4000 Hertz at the intensities of 20, 20, and 25 decibels, respectively in each ear.

This indicator may be met by:

- The local health department maintains on file the Michigan Department of Community Health Hearing Technician's Manual (DCH-0519B, Rev. 6/03) and observation of operating protocols as evidenced through the Technician Observation Program (TOP) indicates compliance with the manual; **AND**
- Appropriate and operational supplies and equipment for hearing technicians to perform preschool and school-age hearing screening.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 3.2

Hearing screening records indicate that a standard air conduction threshold audiogram reading of 250, 500, 1000, 2000, 4000, and 8000 Hertz and unmasked bone conduction thresholds at 250, 500, 1000, 2000, and 4000 Hertz is conducted during Stage II for any child responding inappropriately to any stimulation in either ear during the Intermediate Sweep.

This indicator may be met by:

- The local health department maintains on file the Michigan Department of Community Health Hearing Technician's Manual (DCH-0519B, Rev. 6/03) and observation of operating protocols as evidenced through the Technician Observation Program (TOP) indicates compliance with the manual; **AND**
- Appropriate and operational supplies and equipment for hearing technicians to perform preschool and school-age hearing screening.

Section IV: Hearing

Indicator 3.3

Hearing screening records indicate that any child whose audiogram indicates abnormal hearing is referred for a physician's evaluation and placed on a roster for periodic retesting based on recommended referral criteria.

This indicator may be met by:

The local health department's files on children whose audiograms indicate abnormal hearing confirms that these children are referred for a physician's evaluation and are placed on a roster for periodic retesting based on recommended referral criteria (until two normal, consecutive audiograms obtained).

Documentation Required:

See above.

Evaluation Question:

None

Section IV: Hearing

MPR 4

Where follow-up treatment is required, the local health department shall assure that a written statement indicating necessary course of action is provided to the parent or guardian of the child.

Reference: *PA 368 of 1978, MCL 333.9305(1).*

Indicator 4.1

Documentation exists that written statements indicating the necessary course of action has been provided to parents or guardians of children whenever follow-up examination or treatment is necessary as a result of hearing screening.

This indicator may be met by:

The local health department maintains on file parent letters indicating confirmation of the process for follow-up of children referred from Stage II screening.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 4.2

Documentation demonstrates that children referred for examination or treatment have received the recommended services.

This indicator may be met by:

The local health department maintains on file otology clinic reports, documentation from physicians (DCH-0381 or letter), or confirmation from parents that children have received treatment.

Documentation Required:

See above.

Evaluation Question:

None

Section IV: Hearing

MPR 5

The local health department shall assure that individuals administering the screening and testing are trained in accordance with curriculum approved by MDCH.

Reference: Michigan Administrative Code, R 325.3273.

Indicator 5.1

All hearing technicians have attended a Michigan Department of Community Health approved training (Stage I and Stage II) and received passing grades in both written testing and practical application.

This indicator may be met by:

Hearing technician certificates confirming that technicians have participated and passed the approved Michigan Department of Community Health training course for the Hearing Screening Program.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 5.2

All hearing technicians have attended at least one Michigan Department of Community Health approved skills workshop within the last 24 months.

This indicator may be met by:

The local health department maintains on file attendance certificates from Michigan Department of Community Health Annual Technician Workshops.

Documentation Required:

See above.

Evaluation Question:

None

Section IV: Hearing

MPR 6

A local health department shall conduct periodic free hearing programs for the testing and screening of children residing in its jurisdiction. The time and place of the programs shall be publicized.

Reference: *PA 368 of 1978, MCL 333.9301.*

Indicator 6.1

All hearing screening services are provided to children without charge to parents or guardians.

This indicator may be met by:

- A written policy or program plan articulating the opportunity to receive free preschool and school-age hearing screening services; AND
- Documentation of public bulletins, public service announcements and media advertisements that publicize opportunities for free preschool and school-age screening.

Documentation Required:

See above.

Evaluation Question:

None

Section V: Immunization

MPR 1

The local health department shall offer immunization services to the public following a comprehensive plan to assure full immunization of all citizens living in the jurisdiction.

References: *Omnibus Reconciliation Act of 1993, section 1928 and Part IV- Immunizations, Sec. 13631; Current Vaccines for Children (VFC) Operations Guide; Current Immunization Program Operations Manual (IPOM); PA 368 of 1978, MCL 333.9203; MCL 333.2433(1); WIC Policy Memorandum #2001; Current Comprehensive Agreement (annual); Resource Book for VFC Providers (updated annually); Current Advisory Committee on Immunization Practices (ACIP) General Recommendations on Immunization*

Indicator 1.1

The LHD shall offer vaccines to the public for protection in case of an epidemic or threatened epidemic of a vaccine preventable disease.

This indicator may be met by:

The LHD shows evidence of public health preparedness for vaccine preventable diseases.

Documentation Required:

Evidence that follow up to a VPD has occurred.

Evaluation Question:

Does the LHD have access to the CDC Manual for Surveillance of Vaccine-Preventable Diseases and to the most current MDCH Vaccine Preventable Disease Investigation Guidelines?

Indicator 1.2

LHD conducts free periodic immunization clinics for those residing in its jurisdiction. Clarification: "free periodic immunization clinics" refers to public vaccine, particularly VFC vaccine, VRP vaccine, and Section 317 funded vaccine. The LHD must be conducting clinics and administering vaccines.

This indicator may be met by:

- The LHD offers all vaccines recommended by the Vaccines for Children (VFC) Program to those residing in its jurisdiction.
- The LHD is a VFC provider.

Documentation Required:

- Documentation of all walk-in and appointment based clinic hours and locations showing availability to meet the public demand.
- LHD VFC enrollment and profile forms for the past three years.

For technical assistance, please contact Christopher Smith at 517-335-8333 or smithc63@michigan.gov

Section V: Immunization

Evaluation Questions:

- Does the LHD provide age appropriate vaccine as recommended by VFC?
- How does the LHD meet the public demand to vaccinate individuals?
- How are clinic hours publicized?
- Are walk-in clients accepted?
- Are appointments able to be scheduled within a four week time period?
- Does the LHD offer vaccines through other special MDCH publicly funded vaccine programs?

Indicator 1.3

The local health department uses the IAP mechanism to improve jurisdiction and LHD immunization rates, assure convenient, accessible clinic hours, coordinate immunization services, provide educational and technical services, and develop private and public partnerships.

This indicator may be met by:

- The LHD submits semi-annual Immunization Action Plan (IAP) reports on or before the due date each year.
- The LHD submits an annual IAP plan by the due date each year.
- At least one representative from each local health department will attend the IAP meetings held twice a year.

Documentation Required:

- IAP reports submitted for the last 3 years.
- IAP plans submitted for the last 3 years.

Evaluation Questions:

- Did at least one representative from each local health department attend each of the bi-annual IAP meetings according to MDCH IAP Coordinator Meeting sign-in sheets?
- Did the LHD submit all IAP reports on time in the last 3 years?
- Did the LHD submit an annual IAP plan on time for the last 3 years?

For technical assistance, please contact Christopher Smith at 517-335-8333 or smithc63@michigan.gov

Section V: Immunization

Indicator 1.4

The local health department shows evidence that the LHD recalls children not up to date for vaccines.

This indicator may be met by:

- The LHD conducts reminder and/or recall (recall is required) efforts at least quarterly and details which methods were used (cards, letters, phone calls, other methods of outreach).
- The LHD participates in collaborative efforts with private providers to promote/implement a recall system.

Documentation Required:

- Documentation of the number of reminder and/or recall notices sent to LHD clients and details about which methods were used (cards, letters, phone calls, other methods of outreach).
- Review of three client records that have been tracked showing response to recall.
- Documentation of ongoing efforts to work with private providers to promote reminder/recall activities (e.g. educational, MCIR-related, or other collaborative efforts).

Evaluation Questions:

None

Section V: Immunization

MPR 2

The local health department adheres to immunization policies and professional standards of practice as detailed in the *Standards for Child and Adolescent Immunization Practices* and the *Standards for Adult Immunization Practices.*

References: *Omnibus Reconciliation Act of 1993, section 1928 and Part IV- Immunizations, Sec. 13631; The National Vaccine Advisory Committee (NVAC) The Standards for Child and Adolescent Immunization Practices; Standards for Adult Immunization Practices; Current Immunization Program Operations Manual; Current AIM Provider Toolkit (annual); Current Advisory Committee on Immunization Practices (ACIP) General Recommendations on Immunization*

Indicator 2.1

The LHD adheres to guidelines found in the Standards for Child and Adolescent Immunization Practices and Standards for Adult Immunization Practices regarding vaccination policies for their own clients.

This indicator may be met by:

- Barriers to vaccination should be identified and minimized at the local health department.
- Patient "out-of-pocket" costs are minimized.
- Vaccinations are coordinated with other healthcare services being provided at the health department.
- Clients seeking healthcare services at a local health department should be assessed at every encounter to determine which vaccines are indicated.
- Office or clinic-based patient record reviews and vaccination coverage assessments are performed annually.

Documentation Required:

- Fee schedule.
- Method of notification used to let clients know that immunization fees can be waived for publicly purchased vaccines.

Evaluation Questions:

- Do other LHD programs, including those that serve adolescents and adults, screen and refer clients to the immunization clinic or private provider?
- Has the LHD addressed focus efforts identified for improved immunization processes during the last AFIX review?

Section V: Immunization

Indicator 2.2

The LHD adheres to guidelines found in the Standards for Child and Adolescent Immunization Practices and Standards for Adult Immunization Practices when administering vaccines to clients.

This indicator may be met by:

- Written up-to-date vaccination protocols are easily accessible at all locations where vaccines are administered.
- Local health department staff should simultaneously administer as many indicated vaccine doses as possible.
- Only true contraindications should be used when vaccinating individuals.
- Proper counseling of persons receiving vaccines should be performed explaining immunization risks and benefits including the distribution of the Michigan VIS.
- All required fields for vaccination must be properly documented and records are easily accessible.

Documentation Required:

- One complete up to date Immunization Manual, signed annually by the LHD Medical Director, available (standing orders and emergency treatment orders) at each immunization clinic site.
- LHD immunization screening tool.
- Current guide to contraindications located at each clinic site (i.e., most current CDC Guide to Contraindications to Vaccinations or AIM Provider Tool Kit Guide to Contraindications).
- LHD educational materials explaining immunization risks and benefits including VIS.
- Current immunization educational/promotional materials at each site.

Evaluation Questions:

- Are current ACIP recommendations published in the *MMWR*, ACIP/VFC resolutions, and guidelines to contraindications for pediatric and adult immunizations included in the standing orders?
- Does a review of LHD client vaccine administration records show that there are no missed opportunities to vaccinate?
- Does a review of LHD client vaccine administration records at all clinics show that all required immunization documentation is correct?

Indicator 2.3

The LHD adheres to guidelines found in the Standards for Child and Adolescent Immunization Practices and Standards for Adult Immunization Practices regarding immunization policies for local health department staff.

For technical assistance, please contact Christopher Smith at 517-335-8333 or smithc63@michigan.gov

Section V: Immunization

This indicator may be met by:

- LHD ensures that immunization staff has been properly trained and updated on immunization practices.
- Personnel who have contact with patients are encouraged to be appropriately vaccinated.

Documentation Required:

- Evidence of any staff training regarding current immunization practices/standards during the past three years and a list of CE/CNE's for those who administer vaccine to ensure immunization staff has been properly trained
- Evidence of any training regarding current immunization practices/updates during the past three years that the Medical Director has received
- Public Health Nurse (PHN) immunization orientation plan to assure immunization staff has been properly trained
- Evidence of encouragement and/or programs to vaccinate LHD staff
-

Evaluation Questions:

None

Indicator 2.4

The LHD adheres to guidelines found in the Standards for Child and Adolescent Immunization Practices and Standards for Adult Immunization Practices by promoting immunizations within their jurisdiction.

This indicator may be met by:

Patient-oriented and community-based approaches to increase immunization levels within the health jurisdiction (e.g. use of community data/demographics, client surveys, and foreign language materials as appropriate for community, etc.)

Documentation Required:

- Evidence of patient-oriented and community-based approaches (e.g. use of community data/demographics, client surveys, and foreign language materials as appropriate for community, etc.)
- Policies and/or written agreement with WIC clinics in the jurisdiction to promote immunization of WIC clients, including documentation that shows the LHD has encouraged the use of MCIR by WIC clinics
- WIC MCIR immunization coverage levels for all WIC clinics within the LHD jurisdiction

Evaluation Question:

- What efforts does the LHD undertake to promote adolescent and adult immunizations?

Section V: Immunization

MPR 3

The LHD shall comply with federal requirements of the Vaccines for Children (VFC) entitlement program.

References: *Current Immunization Program Operations Manual (IPOM); Omnibus Reconciliation Act of 1993, section 1928 and Part IV- Immunizations, Sec. 13631; Current Vaccines for Children (VFC) Operations Guide; CDC Manual for the Surveillance of Vaccine-Preventable Diseases; Resource Book for VFC Providers MDCH (updated annually); ACIP/VFC Recommendations; Current Comprehensive Agreement MDCH VFC/AFIX Site Visit Guidance*

Indicator 3.1

The local health department shall assure adequate storage and handling of vaccines that it administers and distributes. **(Immunization Program Operations Manual, 2.1 AND Omnibus Reconciliation Act of 1993)**

This indicator may be met by:

- Annual enhanced VFC site visits at each LHD vaccine storage site with no outstanding issues.
- The local health department has appropriate equipment and monitoring devices to safely store vaccine at each of its clinic sites.
- The local health department can demonstrate that all staff responsible for storage and handling of vaccines are familiar with and have access to the most current CDC storage and handling guidelines and other guidelines, information and policies related to storage and handling that are provided by MDCH.
- The local health department has procedures in place to assure appropriate storage of vaccines and demonstrates these procedures.
- The local health department uses appropriate storage and handling methods in the ordering of vaccines and the transport of vaccines to off-site clinics and to other providers.

Documentation Required:

- Enhanced VFC site visit questionnaires, and enhanced VFC site visit corrective action forms (if applicable), for all LHD vaccine storage sites, which address the required documentation listed below:
    - Up to date written policies and procedures for the safe storage of vaccines, that are consistent with the most recent CDC storage and handling guidelines, at each LHD clinic site where vaccine is stored and these policies and procedures readily available to all staff involved in vaccine storage and handling.
    - Written emergency procedure within the Immunization Manual for responding to vaccine storage problems that is up to date and easily accessible to all staff responsible for handling vaccines.
    - The name and location of an adequate back-up storage site and the written agreement updated annually stating that the site will serve as back-up for vaccine storage.

For technical assistance, please contact Christopher Smith at 517-335-8333 or smithc63@michigan.gov

- The past 90 days of temperature logs, monitored and recorded twice daily for each of the units used to store vaccine.

- Calibration charts from the last three months showing weekly documentation of the sensaphone/alarm temperature, and Dickson pen (not digital read-out) or other continuous temperature recording device reading as compared to a certified thermometer reading. Calibration charts must also show documentation of any adjustments made to the sensaphone/alarm and/or Dickson pen (or other continuous graphing thermometer device) during each weekly time period to bring all devices within three degrees Fahrenheit of the certified thermometer temperature.

- Written policy within the Immunization Manual requiring the use of coolers and appropriate coolant when transporting vaccine.

Evaluation Questions:

- Do the enhanced VFC site visit questionnaires, and enhanced VFC site visit corrective action forms (if applicable), show compliance with the following questions for all LHD vaccine storage sites?

  - Does the local health department have adequate equipment to store frozen vaccine at all of its clinical sites where vaccine is routinely administered?

  - Does the local health department have adequate equipment to store refrigerated vaccines at its own facilities' clinical sites?

  - Are plug guards or other mechanisms to prevent unwanted disconnection from the power supply present for each refrigerator and freezer used to store vaccine and a 'DO NOT DISCONNECT' warning which is visible at the outlet and circuit breaker used for each unit?

  - Does each refrigerator/freezer have a certified thermometer, recording thermometer, and, for each unit used in the routine storage of vaccines which exceed $1,000 in total value per unit, an alarm system in place and operational?

  - Is a certified thermometer located centrally in each vaccine storage unit/compartment?

  - Does the local health department routinely order vaccine according to their Tiered Ordering Frequency (TOF) schedule?

  - Does the local health department have the current CDC Vaccine Management Guide in view and at all vaccine storage sites?

  - Does a visual inspection of vaccine storage equipment and vaccines demonstrate that the local health department complies with CDC storage and handling guidelines?

  - Does a check of sensaphone/alarm show appropriate settings for the following: current status/settings, sensaphone is plugged into a hard line analog phone line, power supply with battery backup and that the alarm system is operational?

  - Does a check of the Dickson graphing thermometer (or other continuous monitoring thermometer) for the past 90 days show temperatures within range at all times, that charts have been changed weekly, pen

tracing appropriately with temperatures matching calibration chart readings, and use of correct charts for each Dickson model?

- Is the vaccine monitoring system functional and a review of the settings of the system shows the ability to notify personnel in case of a vaccine management emergency?
- There are no accident reports attributable to negligence on the part of the LHD filed, without satisfactory resolution of the problem, for any of its sites since its last accreditation review.
- Are vaccines handled appropriately in the clinic setting between main storage and administration of the vaccine?

Indicator 3.2

The local health department shall assure that all requirements for participation in vaccine programs (including VFC and other vaccine distribution programs) are met. **Reference: Vaccines for Children Operations Guidelines, IPOM**

This indicator may be met by:

- The local health department reviews and sends the Michigan Department of Community Health a VFC provider enrollment form and profile form for the agency and for each participating health care provider, including each community/migrant/rural health center in its jurisdiction, no later than February 15 of each year.
- The local health department completes the Michigan Department of Community Health vaccine dose reporting forms, temperature charts, and vaccine inventory forms and submits to MDCH as supporting documentation with orders.
- The LHD processes provider VFC vaccine orders in a timely manner and assures that ordering requirements are met for each scheduled order.
- The local health department adheres to ACIP recommendations published in the MMWR, ACIP/VFC resolutions, and guidelines to contraindications for pediatric, adolescent and adult immunizations.
- The local health department maintains on file a sample of written informational material provided to private providers regarding requirements for the VFC Program during the enrollment process.
- The local health department will perform VFC/AFIX site visits to VFC providers in its jurisdiction, according to minimum and maximum standards formulated by MDCH.
- The local health department documents and reports to MDCH appropriate follow-up to Corrective Plans of Action (CPAs) resulting from VFC/AFIX site visits.
- The local health department assesses each client's eligibility for the VFC Program and other publicly funded vaccine programs.
- The LHD works with providers to avoid vaccine fraud, abuse and wastage.

Section V: Immunization

Documentation Required:

- Documentation of required number of VFC/AFIX site visits completed for the past 3 years with all CPAs addressed. Prior to 2013, LHD's will visit at least 20 VFC provider sites each year and jurisdictions with 20 or fewer providers should visit at least 80% of their sites each year. Beginning in 2013, LHDs will visit at least 50% of VFC provider sites each year and the remaining 50% the following year so that all sites receive a VFC site visit at least once every two years. The city of Detroit is expected to visit 100% of their providers annually using Quality Assurance Specialists (QAS) as assigned to Detroit.

- Written protocols or procedures in the Immunization Manual used to assure each client's eligibility for the VFC Program and other publicly funded vaccine programs.

- Copies of the VFC provider enrollment form and provider profile form (paper or stored in MCIR) for the agency and for each participating health care provider, including each community/migrant/rural health center, in its jurisdiction submitted by February 15th of each year for the past three years.

- Protocol within the Immunization Manual describing the process for recruiting and enrolling new providers into the VFC program.

- LHD billing shows that VFC eligible children are not billed more than the maximum amount allowed for the vaccine administration fee by Centers for Medicare & Medicaid Services CMS.

- LHD protocol for follow-up on publicly purchased vaccine wastage and/or suspected fraud/abuse of publicly purchased vaccine.

Evaluation Questions:

- Does a review of LHD vaccine orders show that the LHD has submitted and reviewed the supporting documentation required with their own vaccine orders?

- What process is in place at the LHD to assure that provider vaccine orders submitted in MCIR are received and processed in a timely manner?

- Does a review of provider vaccine orders show that the LHD has reviewed the order and required supporting documentation submitted with the order?

- Is the LHD profile consistent with the amount of vaccine ordered?

- How does the LHD target providers for VFC/AFIX site visits with over 100 children, storage and handling issues or other issues?

- Does the LHD conduct the combined VFC/AFIX visit at site visits for providers who have any children in the 19 – 36 month age range?

- Can the LHD show examples of efforts to educate providers on vaccines, immunization guidelines and publicly purchased vaccine program guidelines?

- Are all vaccine loss reports within the health jurisdiction reported according to MDCH procedures?

Section V: Immunization

MPR 4

The local health department shall be an active participant and user of the Michigan Care Improvement Registry (MCIR).

References: *Michigan Administrative Code, R 325.164 (4.2); PA 368 of 1978; Current Comprehensive Agreement; PA 540 of 1996; Michigan Administrative Code, R 325.163, Michigan Administrative Code, R 333.2433(2b, 2d)*

Indicator 4.1

The local health department shall sustain an immunization level for their jurisdiction in the MCIR of at least 70% for children who are 19 through 35 months of age for four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity); and four (4) doses of pneumococcal conjugate vaccine (or complete series).

This indicator may be met by:

A jurisdiction rate at or above 70% for the 4:3:1:3:3:1:4 vaccine series as shown by MCIR county profile report(s) created within 30 days of the accreditation review.

Documentation Required:

- MCIR Profile Report(s) showing the number and percent of children who have received four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity), and four (4) doses of pneumococcal conjugate vaccine (or complete series), (4:3:1:3:3:1:4 series) for all counties in the jurisdiction within 30 days of the accreditation review.

- Written protocol included in the Immunization Manual to maintain an immunization level of 70% or more for the 4:3:1:3:3:1:4 series in the MCIR for children aged 19 through 35 months which includes strategies to reach identified pocket of need areas.

Evaluation Questions:

- Has the local health department reached at least a seventy percent (70%) level for children 19 through 35 months of age within the local health department's jurisdiction as recorded in the MCIR for the 4:3:1:3:3:1:4 series within 30 days of the accreditation review?

Indicator 4.2

The local health department shall monitor and evaluate adolescent immunization coverage levels for children 156 months but not yet 216 months old in their jurisdiction in the MCIR for one (1) dose Td/Tdap plus the primary series; three (3) doses of polio vaccine; two (2) doses of MMR vaccine; three (3) doses of hepatitis B vaccine; two (2) doses of varicella vaccine (or documented immunity); and one dose meningococcal conjugate vaccine. The LHD will also monitor and evaluate the adolescent immunization coverage in their jurisdiction for three (3) doses of human papillomavirus (HPV) vaccine for females 156 months but not yet 216 months old.

Section V: Immunization

This indicator may be met by:

- The LHD runs and evaluates on a monthly basis the MCIR adolescent immunization coverage level reports for children 156 months but not yet 216 months old in their jurisdiction in the MCIR for one (1) dose Td/Tdap plus the primary series; three (3) doses of polio vaccine; two (2) doses of MMR vaccine; three (3) doses of hepatitis B vaccine; two (2) doses of varicella vaccine (or documented immunity); and one dose meningococcal conjugate vaccine.

- The LHD runs and evaluates MCIR coverage level reports for three (3) doses of human papillomavirus (HPV) vaccine for females 156 months but not yet 216 months old in the jurisdiction.

Documentation Required:

- MCIR adolescent coverage level reports for all counties in the jurisdiction for the three months prior to the review showing coverage levels for one (1) dose Td/Tdap plus the primary series, three (3) doses of polio vaccine; two (2) doses of MMR vaccine; three (3) doses of hepatitis B vaccine; two (2) dose of varicella vaccine (or documented immunity) and one dose meningococcal conjugate (MCV4) vaccine.

- MCIR coverage level reports for all counties in the jurisdiction for the three months prior to the review showing coverage levels for three (3) doses of human papillomavirus (HPV) vaccine for females 156 months but not yet 216 months old.

- Written protocol included in the Immunization Manual to conduct efforts to increase adolescent immunization coverage levels within the jurisdiction.

Evaluation Question:

- What efforts has the LHD conducted to target and increase adolescent immunization coverage levels in the jurisdiction?

Indicator 4.3

The local health department shall submit immunization data to the MCIR according to the statutory time lines.

This indicator may be met by:

There is evidence that 80% of clients born since 1994 receiving immunizations at the local health department (all clinics in jurisdiction combined) have their immunization data submitted to the MCIR within 72 hours. Reference: Administrative Rule 325.163, § 5.

Documentation Required:

- MCIR Business Objects reports for all counties within the jurisdiction for 90 consecutive days prior to the review showing 72 hour data submission.

Evaluation Question:

Section V: Immunization

- Did 80% of the clients born since 1994 receiving immunizations at the local health department (all clinics in jurisdiction combined) have their immunization data submitted to the MCIR within 72 hours of vaccine administration?

Section V: Immunization

MPR 5

The local health department uses the combined MCIR and School Immunization Record-keeping System (SIRS) web-based program (MCIR/SIRS) to track immunization levels of childcare center enrollees and school children.

References: *Current Comprehensive Agreement; PA 368 of 1978, MCL 333.9208, MCL 333.9209, MCL 333.9211, MCL 333.9212, MCL 333.9215, MCL 333.9221; PA 94 of 1979, MCL 388.1767; PA 451 of 1976, MCL 380.1177.*

Indicator 5.1

The local health department uses the MCIR/SIRS reporting web-based program to assure complete and accurate data has been submitted for school entrants and sixth grade children by December 15 and March 15 of each school year.

This indicator may be met by:

The local health department will assure complete and accurate school immunization data for all schools in the jurisdiction have been reported December 15 and March 15 of each year to MDCH.

Documentation Required:

- Written procedures including MDCH Protocols in addition to any health department protocols that detail the methods for reviewing school immunization data.
- IP-100 County status reports for each reporting period for the past three years.
- Documentation showing timely submission of complete and accurate school data by December 15 and March 15 of each year.
- Evidence of follow up for non-compliant or delinquent schools which appear on the status report.

Evaluation Questions:

- Does the LHD update/maintain the school facility master listing in MCIR/SIRS?
- What methods are used by the LHD to promote that data submitted by schools is complete and accurate?

Indicator 5.2

The local health department will assure complete and accurate reporting of childcare center immunization data by February 1st of each year to MDCH. **Reference: PH code 333.9208**

For technical assistance, please contact Christopher Smith at 517-335-8333 or smithc63@michigan.gov

Section V: Immunization

This indicator may be met by:

The local health department will assure complete and accurate childcare immunization data has been reported by February 1st of each year to MDCH.

Documentation Required:

- Written procedures including MDCH Protocols in addition to any health department protocols which detail the methods for reviewing childcare immunization data.
- IP-101 County status reports for each reporting period for the past three years.
- Documentation showing timely submission of complete and accurate childcare data by February 1 of each year.
- Evidence of follow up for non-compliant or delinquent childcare centers which appear on the status reports.

Evaluation Questions:

- Does the LHD update/maintain the childcare facility listing in MCIR/SIRS?
- What methods are used by LHD to promote that data submitted by childcares is complete and accurate?

Section V: Immunization

MPR 6

The local health department complies with vaccine safety recommendations.

References: *Vaccine Adverse Event Reporting System (VAERS); The National Childhood Vaccine Injury Act of 1986 (NCVIA); Federal Register 42 USC § 300aa-25, 42 USC§ 300aa-26; Resource Book for VFC Providers MDCH (updated annually); Current Advisory Committee on Immunization Practices (ACIP) General Recommendations on Immunization*

Indicator 6.1

The local health department vaccine programs conform to VAERS (Vaccine Adverse Event Reporting System) program requirements.

This indicator may be met by:

The LHD maintains on file written VAERS policies, procedures, and reports complying with program requirements.

Documentation Required:

- VAERS written policy in the Immunization Manual which includes information on utilization of up to date reporting forms (available at the U.S. Department of Health & Human Services VAERS website) and the ability to submit VAERS reports online.
- Copies of all VAERS reports filed by the LHD in the last three years (either electronically or on paper forms) showing correct documentation on up to date forms.

Evaluation Question:

None

Indicator 6.2

The local health department provides the appropriate Vaccine Information Statements (VIS) to every client or parent/guardian prior to administering vaccines and educates all immunization providers in the jurisdiction about the use and sources of these statements.

This indicator may be met by:

- The LHD distributes VIS to all clients receiving vaccine listed on the National Vaccine Injury Compensation Program table at the clinic and documents the VIS date and date VIS given on the client's vaccine administration record.
- There is a protocol in place to assure that all providers within the jurisdiction who administer vaccines (both VFC and non-VFC providers) are informed concerning the requirements for use of Vaccine Information Statements (VIS), and changes to VIS versions.

- The local health department maintains an appropriate supply of VIS on site for distribution to all immunization providers.

- The local health department will provide written notice to individuals receiving a vaccination that the immunization data will be added to the registry. This is commonly done using the Michigan version of the Vaccine Information Statement (VIS) which includes the MCIR language.

Documentation Required:

- Up to date Michigan VIS versions for all recommended vaccines included on the National Vaccine Injury Compensation Program table are available for distribution to clients and private providers.

- Protocol which describes the plan for VIS education and distribution to all immunization providers (both VFC and non-VFC) who administer vaccines within the jurisdiction.

Evaluation Question:

- Does the LHD use the version of the VIS that contains the MCIR statement informing an individual of their right to opt out of the MCIR?

Indicator 6.3

The local health department has a referral system if problems arise after a client receives vaccine.

This indicator may be met by:

The LHD provides instructions for patients receiving vaccines concerning possible reactions and follow-up care.

Documentation Required:

- Example(s) of patient information handouts given to each patient, listing possible reactions to vaccines, which include phone numbers to contact if questions arise.

Evaluation Questions:

None

Section VI: On-Site Wastewater Treatment Management

MPR 1

The local health department shall have a wastewater treatment regulation capable of protecting the public health legally adopted under enabling state legislation. The regulation shall authorize an enforcement process that is utilized and includes the capability to deny permits, issue orders for corrections of failed systems, and/or other remedies for construction without a permit or for violating an order.

References: *Sections 2433 through 2446 of the Public Health Code, 1978 PA 368, as amended; Part 31, Water Resources Protection, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended; and Part 22, administrative rules.*

Indicator 1.1

Documentation that a wastewater treatment regulation is contained in a local sanitary code or ordinance legally adopted by the authorized local governing entity.

To fully meet this indicator:

The local health department maintains on file a copy of the local sanitary code and documentation confirming it has been legally adopted.

Documentation Required:

- Local health department sanitary code, ordinance and/or other regulation(s).
- Documentation from the authorized local governmental bodies that confirms the sanitary code, ordinance and/or other regulation(s) have been legally adopted.

Compliance Measurement:

Determine that documentation is provided that demonstrates the wastewater treatment regulation contained in the local sanitary code, ordinance, and/or other regulation(s) specific to wastewater treatment systems are legally adopted by the authorized local governing entity.

Evaluating Compliance:

Met – The local sanitary code, ordinance, and/or other regulation(s) have been lawfully adopted.

Met with Conditions –The local sanitary code, ordinance, and/or other regulation(s) have been lawfully adopted; however, evidence exists that the agency is operating outside of the authority of the local sanitary code, ordinance, and/or other regulation(s).

Not Met – The local sanitary code, ordinance, and/or other regulation(s) are not lawfully adopted.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Indicator 1.2

Evidence that the local wastewater treatment regulation authorizes enforcement measures, including permit denials, correction orders, and/or other remedies.

The local health department maintains on file the specific sanitary code provisions that define the basis of denial and enforcement.

Documentation Required:

- Local health department sanitary code, ordinance, and/or other regulation(s).
- Local health department on-site wastewater policy manual.

Compliance Measurement:

- Determine that the local sanitary code or ordinance and other regulations authorize an enforcement process that includes:
    - Capability to deny permits,
    - Issue orders for system failure corrections,
    - Other remedies for construction without a permit or violating an order.
- Determine that the local sanitary code or written guidelines or policies are in existence that directs enforcement activities.

Evaluating Compliance:

Met – The review determines all of the following:

- The local sanitary code, ordinance, and/or other regulation(s) contain provisions for enforcement.
- The local sanitary code or written guidelines or policies exist that provide direction on uniform procedures for enforcement.

Met with Conditions – The review determines that the local sanitary code, ordinance, and/or other regulation(s) contain provisions for enforcement; however, evidence exists that the code or agency's written guidelines and/or policies provide inadequate direction on enforcement procedures.

Not Met – The local sanitary code, ordinance, and/or other regulations do not contain provisions for enforcement.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Indicator 1.3

Evidence that actual enforcement measures are utilized.

To fully meet this indicator:

The local health department maintains on file, retrievable documentation for denials and/or enforcement actions.

Documentation Required:

- Logbooks, computer database, and/or other method used to document and track enforcement.
- Examples of enforcement.

Compliance Measurement:

- Determine if permit denials exist.
- Determine if enforcement actions exist, which could include any of the following:
    - Record of actions taken on complaints regarding on-site wastewater.
    - Installation compliance orders.
    - Record of actions taken against recalcitrant installation contractors.
- Determine that the agency is following the code provisions or written guidelines or policies.

Evaluating Compliance:

Met – The review determines all of the following:

- Evidence of enforcement exists in logbooks, computer database, and/or other examples of enforcement actions.
- The agency is following the code provisions or written guidelines or policies.

Met with Conditions – The review determines any of the following:

- There is evidence of enforcement action being taken; however, such actions are not being routinely documented.
- The agency is inconsistently following code or the written guidelines and/or policies.

Not Met – The review determines any of the following:

- Enforcement measures as provided by the local sanitary code, ordinance, and/or other regulation(s), and/or the agency's written guidelines, and/or policies to direct staff on uniform enforcement procedures are not being taken by the agency.
- The agency cannot provide retrievable documentation of enforcement actions authorized by the code.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

MPR 2

The local health department shall evaluate all parcels of land and authorize the installation of any on-site wastewater treatment system in accordance with applicable regulation(s). The evaluation shall employ a site specific physical assessment of the soil's treatment and transport capacity and determine compliance with applicable regulations. Site conditions, including soil profile data obtained from on-site evaluations, shall be accurately documented. Documentation shall be maintained in an organized and functional filing system that provides retrievable information.

References: *Sections 2433 through 2446 of the Public Health Code, 1978 PA 368, as amended; Part 31, Water Resources Protection, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended; Part 22, administrative rules; and Part 4, Department of Environmental Quality Administrative Rules for On-Site Water Supply and Sewage Disposal for Land Divisions and Subdivisions, R 560.406 to R 560.428.*

Indicator 2.1

Documentation of a site evaluation visit, which includes the soil characteristics, seasonal high water table, slope, isolation distances, location, and available area for initial and replacement systems.

To fully meet this indicator:

The local health department maintains on file recorded results of site evaluation visits that accurately document the required information.

Documentation Required:

- Sample – Random selection of wastewater permit documents (per Appendix A – Permit Selection Protocol) inclusive of site evaluation documentation.
- Local health department on-site wastewater policy manual.

Compliance Measurement:

- Determine that documentation of all site evaluations minimally identify the following essential elements:
    - The location of the soil boring(s) or excavation(s) which establish the approved area for the proposed absorption system to be installed shall be documented in a verifiable manner. See Appendix B.
    - Soil profile data
        - Soil texture for each distinct horizon* inclusive of topsoil to the depth of the boring or excavation.
        - Thickness of each soil horizon to the depth of the boring or excavation.

*Note- A horizon for the purpose of this guidance is defined as a soil layer which has a uniform texture.

        - Seasonal high water table

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

- Clearly document if absent, and,
- Specific depth when present in the soil profile.

- Determine that site factors that may affect system design and construction, including slope and required isolation distance, are evaluated and noted on documentation when applicable.

- Determine that the location and area available for initial and replacement systems is considered as part of the site evaluation*.

*Note: The requirement for identifying a replacement system applies to issuance of new construction permits only.

Evaluating Compliance:

Met – At least 80 percent or more of site evaluation documents reviewed contain all of the essential elements.

Met with Conditions – At least 70 percent or more of site evaluation documents reviewed contain all of the essential elements.

Not Met – Less than 70 percent of the documents reviewed contain all of the essential elements

Indicator 2.2

Permit documentation of the system location, design installation requirements, pertinent site characteristics, and nature of the building development.

To fully meet this indicator:

The local health department maintains on file the detailed plan and specifications prepared for each system for which a permit has been issued. The plan and specifications shall accurately define initial and replacement system location*, size, other pertinent construction details, and include documentation of variances, when granted.

*Note: The requirement for identifying a replacement system applies to issuance of new construction permits only.

Documentation Required:

- Sample – Random selection of wastewater permit documents (per Appendix A – Permit Selection Protocol).

- Local health department on-site wastewater policy manual.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Compliance Measurement:

Permit documentation includes the following essential elements:

- Absorption System Location – The approved location for the absorption system identified during the site evaluation shall be communicated by an acceptable method (see Appendix B) as part of the following:
    - Drawing, or
    - Description
- Design/Installation Requirements
    - Specifications for system components that are to be installed, including treatment units, sizing of septic tank(s) and pump tank(s); type of absorption system, size and depth; and type of fill, if needed
    - Requirements for inspections are identified.
- Pertinent Site Characteristics
    - Isolation to water wells, surface water, slope, or other factors are identified as appropriate.
- Replacement Area - A replacement area is identified as part of a new construction permit as follows:
    - Drawing, or
    - Description

Evaluating Compliance:

Met – At least 80 percent or more of wastewater permit documents reviewed contain all of the essential elements.

Met with Conditions – At least 70 percent or more of wastewater permit documents reviewed contain all of the essential elements.

Not Met – Less than 70 percent of the documents reviewed contain all of the essential elements.

Indicator 2.3

There is evidence of an organized filing system allowing for retrieval of information.

To fully meet this indicator:

The local health department maintains an organized filing system with retrievable information.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Documentation Required:

- Filing system, computer database and/or other method used to retain information relevant to the wastewater treatment program.
- Local health department on-site wastewater policy manual.

Compliance Measurement:

Determine that the results of site evaluations and wastewater permit information are retained in an organized manner and is retrievable.

Evaluating Compliance:

Met – There is an organized filing system, computer database, and/or other method that allows for the consistent retrieval of information.

Met with Conditions – There is an established filing system, computer database, and/or other method to retain information; however, it is not maintained up-to-date to allow for consistent retrieval of information.

Not Met – There is no evidence of an organized filing system, computer database and/or other method to retain information.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

MPR 3

The local health department shall conduct an inspection during construction or prior to covering of the system, or shall apply an alternate method to assure the completed wastewater treatment system complies with permit requirements. Documentation of an inspection or alternate approval method shall be maintained with the permit.

References: *Sections 2433 through 2446 of the Public Health Code, 1978 PA 368, as amended; Part 31, Water Resources Protection, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended; and Part 22, administrative rules.*

Indicator 3.1

Documentation of construction and/or final inspection by the local health department or record of an alternate process to support the approval of the installation in accordance with the permit.

To fully meet this indicator:

The local health department shall conduct an inspection of all systems prior to final cover. The local health department maintains on file an accurate individual record of each inspection conducted during construction of each system. Unless otherwise specifically authorized, installer affidavits, which provide an accurate record of system installation, are maintained on file in isolated cases, representing no more than 10 percent of the total number of final inspections requested, where constraints prohibit inspection by the local health department in a timely manner.

Documentation Required:

- Logbooks and/or computer database.
- Sample – Random selection of wastewater permit documents (per Appendix A – Permit Selection Protocol) inclusive of a final inspection or installer affidavits.
- Local health department on-site wastewater policy manual.

Compliance Measurement:

- Determine that the final inspection completed by the local health department includes a drawing and verification of system components including the following essential elements:
    - Septic Tank(s), pump chamber, and enhanced treatment units
        - Size (septic tanks and pump chambers), as specified on the permit and/or documentation of size installed if different
        - Make and Model Number of treatment unit(s), if applicable
        - Location – See Appendix C
    - Absorption Area
        - Size, as specified on the permit and/or documentation of size installed, if different
        - Location – See Appendix C

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

- Documentation of follow-up inspections when required by the local health department
- Date of final inspection
- Name or initials of staff person conducting the inspection

- Affidavits – If used:

  - Unless specific authorization has been granted, determine that no more than 10 percent of the total numbers of final inspections are installer affidavits through the logbook and/or database or other method that documents affidavit use.
  - Determine that documentation of installer affidavits for final inspections include the following essential elements:
    - A drawing and component verification which identifies the essential elements and key components outlined in Compliance Measurement I. a and b
    - Date of the installation
    - The installer's name

Evaluating Compliance:

Met – The review determines all of the following:

- No more than 10 percent of the final inspections are by affidavit without specific authorization.
- At least 80 percent of the final inspection documents (including affidavits, if used) reviewed contains all of the essential elements.

Met with Conditions – The review determines all of the following:

- No more than 10 percent of the final inspections are by affidavit without specific authorization.
- At least 70 percent of the final inspection documents reviewed contains all of the essential elements.

Not Met – The review determines any of the following:

- More than 10 percent of the final inspections are by affidavit.
- Less than 70 percent of the final inspection documents reviewed contains all of the essential elements.

Section VI: On-Site Wastewater Treatment Management

MPR 4

The local health department shall respond to all wastewater system complaints and maintain records of complaint resolutions.

References: *Sections 2433 through 2446 of the Public Health Code, 1978 PA 368, as amended; Part 31, Water Resources Protection, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended; and Part 22, administrative rules.*

Indicator 4.1

Documentation that all complaints are recorded, evaluated, and investigated, as appropriate.

To fully meet this indicator:

The local health department maintains complaint forms and a filing system containing results of complaint investigations and documentation of final resolution.

Documentation Required:

- Logbooks, computer database, and/or a filing system for complaints regarding on-site wastewater.
- Sample – Random selection of complaints regarding on-site wastewater.
- Local health department on-site wastewater policy manual.

Compliance Measurement:

- Determine that a computer database, and/or filing system exists for retention of the results of complaint investigations.
- Determine that complaints regarding on-site wastewater are logged, investigated, and final resolution is documented as appropriate.
- Determine that a tracking system exists for complaints regarding on-site wastewater to assure final resolution.

Evaluating Compliance:

Met – Complaints as received are logged and investigated; an effective tracking system exists which is used to determine complaint status; and a record of final resolution is documented.

Met with Conditions – The majority of complaints as received are logged and investigated; however, the tracking system is not utilized effectively and as a result, a record of final resolution is not documented in all instances.

Not Met – Complaints as received are not logged and/or not investigated.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

MPR 5

The local health department shall investigate, document and evaluate the probable cause(s) of system failure.

References: *Sections 2433 through 2446 of the Public Health Code, 1978 PA 368, as amended; Part 31, Water Resources Protection, of the Natural Resources and Environmental Protection Act, 1994 PA 451, as amended; and Part 22, administrative rules.*

Indicator 5.1

Approval of permits where the system has failed*, includes retrievable documentation, when available, of the age, design, site conditions; and any other pertinent data allowing for assessment of probable reason(s) for failure and there is an annual summary of data submitted to the Department of Environmental Quality (DEQ).

*Note: For the purpose of this guidance, a soil absorption system is considered to have failed when it backs up into the home, discharges to the ground surface, or contaminates surface water or drinking water supplies.

To fully meet this indicator:

- The local health department maintains a filing system for all failed systems that includes retrievable documentation; **AND**
- Annual failed system data summaries are prepared and are on file.

Documentation Required:

- Filing system and/or computer database for retention of evaluation data regarding failed systems.
- Copy of the form that is utilized for the collection of site/system data when the available standardized form in Appendix D, is not utilized. The collection form shall contain the following minimum data elements:
  - System age
  - Design – type and sizing
  - Site conditions – soil texture and seasonal high water table
  - The probable cause(s) of failure
- Sample – Random selection of failed systems evaluation forms.
- Local health department on-site wastewater policy manual.

Compliance Measurement:

- Determine that evaluations are conducted on all failed wastewater treatment systems.
- Determine that the filing system and/or computer database or other method exists for data retention.
- Determine that annual failed system data summaries are routinely provided to the DEQ.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Evaluating Compliance:

Met – The review determines all of the following:

- A filing system and/or computer database exists for retention of evaluation information and allows for ease of retrieval.
- All of the minimum data elements are being collected on at least 80 percent of failed system evaluations reviewed.
- Annual summaries of failed system data are provided to the DEQ for input into the state-wide failed system database (see Appendix D).

Not Met – The review determines any of the following:

- Evaluations of failed on-site wastewater treatment systems are not occurring, or minimum data elements are being collected on less than 80 percent of failed system evaluations reviewed.
- A filing system and/or computer database does not exist for retention of failed system data.
- Annual failed system data submissions have not been provided to the DEQ for input into the state-wide data summary system (see Appendix D).

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Appendix A

PERMIT SELECTION PROTOCOL

Goal – To collect and evaluate a representative random number of finaled wastewater permits to evaluate compliance with the On-Site Wastewater Treatment Management program indicators VI-2.1, VI-2.2, and **VI-3.1.**

Method

- The sample size for permit reviews will be determined by taking an annual average of permits issued over the review cycle period (previous three years) by 4 percent, or

- Five (5) permits for each staff member with assigned responsibility for the on-site wastewater program will be sampled.

Whichever method above produces the highest permit sample population will be utilized.

Rationale: There is great variability in health departments within the State in terms of the total number of wastewater permits issued and staff members working in the on-site wastewater program. This system has been developed to balance the variability and create a fair and equitable review process.

Note: *Departments with multiple offices will be sampled individually in proportion to the number of permits issued or number of staff members working in the on- site wastewater program in each office.*

Examples:

1. A department that has reported issuing 300 wastewater permits in a fiscal year with two staff members working the on-site wastewater program will have a permit sample size of 12 permits.
    - 300 permits x 4% = 12 permits sampled
    - 2 staff members x 5 permits each = 10 permits sampled

2. A department that has reported issuing 1800 wastewater permits in a fiscal year with twelve staff members working the on-site wastewater program will have a permit sample size of 72 permits.
    - 1800 permits x 4% = 72 permits sampled
    - 12 staff members x 5 permits each = 60 permits sampled

3. A department that has reported issuing 350 wastewater permits in a fiscal year with five staff members working the on-site wastewater program will have a permit sample size of 25 permits.
    - 350 permits x 4% = 14 permits sampled
    - 5 staff members x 5 permits each = 25 permits sampled

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Additional information is obtained and consequently additional weight is given to newly permitted systems. To accomplish this, the sample size will be multiplied by a ratio of replacements to new systems, which is 1:2 (2/3).

Example: If 60 wastewater permits sampled for the review:

- 60 x (2/3) results in 40 new system permits and 20 replacement system permits to be randomly sampled and reviewed.

At the time of review, where information which suggests that original random sample of permits has resulted in the selection of a permit or permits which are not representative of the program, the evaluator is allowed discretion with concurrence of the local health department to eliminate and replace permits and/or increase the overall sample size.

Appendix B

SOIL BORING/EXCAVATION LOCATION DOCUMENTATION

The wastewater treatment system location and design will be based on the information provided by the site and soil evaluation. A site and soil evaluator should be capable of properly conducting site and soil investigations and accurately recording required information so as to be able to communicate the location of the approved area. Various acceptable methods are utilized to record the location of soil boring(s) and/or excavation(s). Soil investigations which have been accurately located allow for the translation of this information onto the subsequent permit documentation utilized in communicating the system design to the installer.

The location of the soil boring(s) or excavation(s) which establish the area for the proposed absorption system shall be documented. Based on completed reviews of local health departments, a range of acceptable methods have been observed. Acceptable methods for documenting the soil boring/excavation location(s) as part of a site evaluation under the On-Site Wastewater Treatment Management program, indicator VI-2.1 include:

1. Two distance measurements from one or more reliable reference points* to the soil boring/excavation location(s).

2. Single compass bearing and distance measurement from a reliable reference point* to the soil boring/excavation location(s).

3. Scaled drawing which shows the soil boring/excavation location(s).

4. In cases of repair/replacement systems, a single distance measurement from an existing permanent benchmark** such as a home, garage, shed, etc. located in close proximity (50 feet) to the soil boring/excavation location(s).

5. Other verifiable method which has been authorized based upon communication with the department. As an example, a number of local health departments have requested and received authorization to utilize a Global Positioning System (GPS) technology to document the soil boring/excavation location(s).

*A reliable reference point is one of a permanent nature expected to be present at the time of absorption system installation, including GPS satellites or one which can be reestablished in the field.

** A benchmark is a specific point of reference from which measurements are made which is expected to remain unchanged throughout the life of the system installation.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Appendix C

FINAL INSPECTION DOCUMENTATION
Locating Key Components

Documentation obtained during the final inspection process not only assures that the system has been properly constructed in accord with the permit requirements but provides necessary information on location of key components including the septic tank, absorption system and other specific components such as pump chambers, enhanced treatment units, etc. The availability of a final inspection drawing which accurately locates these key components serves as an important record for the homeowner, maintenance provider and local health department necessary to provide for effective on-going system management after construction.

Based upon completed reviews of local health departments, various acceptable methods are utilized to document the location of key components which allow for them to be relocated at a later date. With rare exception, at the time of final inspection there are a variety of potential permanent benchmarks** located in close proximity to the installation. Acceptable methods for documenting the location of key components include:

1. Two distance measurements from one or more permanent benchmarks** to septic tanks, pump chambers, enhanced treatment units and absorption areas. Additional options available to absorption areas only, include:

    i. A single distance measurement from a permanent benchmark** is acceptable to the absorption area in instances where the system is located within close proximity (25') to the permanent benchmark**,

    ii. A single distance measurement from a permanent benchmark** is acceptable to a mound system which creates a distinct and separate visible land feature.

2. Single bearing and distance measurement from a permanent benchmark**.

3. Scaled drawing which shows the component location(s).

4. Notation on a drawing of general location of at-grade or above-grade septic tank risers, pump chamber lids, treatment unit access lids or absorption system observation ports where utilized.

5. Other verifiable method which has been authorized based upon communication with the department. As an example, a number of local health departments have requested and received authorization to utilize a Global Positioning System based technology to document the location of key components.

** A benchmark is a specific point of reference from which measurements are made which is expected to remain unchanged throughout the life of the system installation.

Section VI: On-Site Wastewater Treatment Management

Appendix D

Failed System Evaluation
Data Collection and Submissions

For the purpose of this guidance, a failed system shall be defined as follows: **A soil absorption system is considered to have failed when it backs up into the home, discharges to the ground surface, or contaminates surface water or drinking water supplies.**

Indicator 5.1 (Failed System Evaluation) is comprised of three distinct components; (1) collection of failed system/site data, (2) reporting of summarized failed system data to the Department of Environmental Quality (DEQ), and (3) an annual summary report generated by the DEQ and distributed to local health departments.

DEQ Failed System Data Collection Forms (Non-Residential and Residential) – are the mechanisms for capturing all the minimum data elements of this indicator. All failed system data collection forms utilized must contain the minimum data elements captured in these forms. The option to utilize the DEQ standard data collection forms is at the discretion of the local health department. Individual health departments may create and utilize their own forms to collect and analyze information in addition to the minimum elements of this indicator. Consultation with the DEQ is recommended if a health department specific form will be utilized to meet this indicator.

Note: Guidance for completion of the data collection forms has been created to foster consistency in the process of data collection. See the document entitled, "Failed System Data Collection Form – Guidance".

DEQ Failed System Data Submission Forms (Non-Residential and Residential) – are the mechanisms that will be utilized to summarize the data collected on the DEQ Failed System Data Collection Forms (or equivalent forms as discussed above) and for the annual submission of failed system data to the DEQ. Data submissions shall be received within 30 days after the close of each calendar year (February 1). Other methods of data summary and submission may be utilized by local health departments. Consultation with the DEQ is recommended when a health department specific form/database will be utilized to meet this indicator.

The third component will be an annual report generated by the DEQ that will be distributed to all local health departments. The DEQ annual report will summarize all local health department data submissions.

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Date: _____

DEQ Failed System Data Collection Form – Non-Residential

Address: _____ Township: _____ County: _____

Facility Type: ☐ Church ☐ Dental/Medical ☐ Gas Station ☐ Grocery Store ☐ Industrial

☐ Multi-Family ☐ Office/Retail ☐ Restaurant ☐ School ☐ Other _____

Estimated Flows: ☐ <1,000 ☐ 1,000 – 6,000 ☐ >6,001 – 10,000 ☐ >10,000
(gallons per day)

Septic Tank Type:
☐ Single ☐ Two Compartment ☐ More Than One Tank ☐ No Tank

Septic Tank Capacity – Gallons:
☐ <1,000 ☐ 1,000 – 1,500 ☐ >1,500 – 2,000 ☐ >2,000 – 3,000

☐ >3,000 ☐ Unknown

Advanced Treatment Unit ☐ Yes ☐ No If yes, Treatment Unit Name: _____

System Design:
☐ Gravity Bed ☐ Dosed Bed ☐ Pressure Dosed Bed ☐ None

☐ Gravity Trenches ☐ Dosed Trenches ☐ Pressure Dosed Trenches ☐ Unable to Determine

☐ Gravity Mound ☐ Dosed Mound ☐ Pressure Dosed Mound

☐ Chambers ☐ Drywells ☐ Other _____

System Age: (years)
☐ 0 – 5 ☐ 6 – 10 ☐ 11 – 15 ☐ 16 – 20 ☐ 21 – 25
☐ 26 – 30 ☐ 31 – 40 ☐ > 40 ☐ Unknown

Soil Texture:
☐ Coarse Sand, Medium Sand ☐ Fine Sand, Loamy Sand ☐ Sandy Loam

☐ Loam, Sandy Clay Loam ☐ Clay Loam, Silt Loam ☐ Clay, Silt

☐ Organic soil, Fill soil

Seasonal High Water Table: ☐ 0 – 12 ☐ 13 – 24 ☐ 25 – 36 ☐ 37 – 48 ☐ > 48
(inches below grade)

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

System Size: Bed _____ ft² Trenches_____bottom area ft² ☐ Unable to Determine

Probable Cause(s) of Failure:

- ☐ Septic Tank Failure
- ☐ Infrequent Tank Pumping
- ☐ Pipe Filled with Solids
- ☐ Damaged/Collapsed Piping System
- ☐ Hydraulic Overload
- ☐ System Undersized
- ☐ Insufficient Isolation to Water Table
- ☐ Root Intrusion
- ☐ Installation Error
- ☐ Unsuitable Fill
- ☐ Dirty Stone
- ☐ Excess Cover
- ☐ Lack of Maintenance
- ☐ Soil Clogging
- ☐ Unable to Determine
- ☐ Other: _____

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Date: _____

DEQ Failed System Data Collection Form – Residential

Address: _____ Township: _____ County: _____

Dwelling Type: ☐ Single Family ☐ Two-Family

Dwelling Size: ☐ 2 Bedrooms ☐ 3 Bedrooms ☐ 4 Bedrooms ☐ >4 Bedrooms

Septic Tank Type:
☐ Single ☐ Two Compartment ☐ More Than One Tank ☐ No Tank

Septic Tank Capacity – Gallons:
☐ <1,000 ☐ 1,000 – 1,500 ☐ >1,500 – 2,000 ☐ >2,000 – 3,000
☐ >3,000 ☐ Unknown

Advanced Treatment Unit ☐ Yes ☐ No If yes, Treatment Unit Name: _____

System Design:
☐ Gravity Bed ☐ Dosed Bed ☐ Pressure Dosed Bed ☐ None
☐ Gravity Trenches ☐ Dosed Trenches ☐ Pressure Dosed Trenches ☐ Unable to Determine
☐ Gravity Mound ☐ Dosed Mound ☐ Pressure Dosed Mound
☐ Chambers ☐ Drywells ☐ Other _____

System Age: (years)
☐ 0 – 5 ☐ 6 – 10 ☐ 11 – 15 ☐ 16 – 20 ☐ 21 – 25
☐ 26 – 30 ☐ 31 – 40 ☐ > 40 ☐ Unknown

Soil Texture:
☐ Coarse Sand, Medium Sand ☐ Fine Sand, Loamy Sand ☐ Sandy Loam
☐ Loam, Sandy Clay Loam ☐ Clay Loam, Silt Loam ☐ Clay, Silt
☐ Organic soil, Fill soil

Seasonal High Water Table: (inches below grade) ☐ 0 – 12 ☐ 13 – 24 ☐ 25 – 36 ☐ 37 – 48 ☐ > 48

System Size: Bed _____ ft² Trenches_____bottom area ft² ☐ Unable to Determine

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Probable Cause(s) of Failure:

☐ Septic Tank Failure	☐ Infrequent Tank Pumping	☐ Pipe Filled with Solids
☐ Damaged/Collapsed Piping System	☐ Hydraulic Overload	☐ System Undersized
☐ Insufficient Isolation to Water Table	☐ Root Intrusion	☐ Installation Error
☐ Unsuitable Fill	☐ Dirty Stone	☐ Excess Cover
☐ Lack of Maintenance	☐ Soil Clogging	☐ Unable to Determine

☐ Other: _____

Section VI: On-Site Wastewater Treatment Management

Failed System Data Collection Form – Guidance

In May 2010, a workgroup consisting of representatives of the Department of Environmental Quality (DEQ) and the former MALEHA Environmental Affairs Committee convened in part to review and discuss the failed system data that was collected and submitted by local health departments (LHDs) for calendar year 2009. The workgroup's discussion determined that for some elements there were vast differences in interpretation by LHDs and that guidance was needed to establish greater consistency in the future with these aspects. As a result, the following guidance is provided to foster consistency in the process of data collection.

> **Important!** The information collected is intended to be representative of the wastewater system which has failed. For the purpose of this guidance, a soil absorption system is considered to have failed when it backs up into the home, discharges to the ground surface, or contaminates surface water or drinking water supplies.

For Non-Residential systems: Indicate the facility type and estimated gallons per day flow.

For **Facility Type**, the following further descriptions are provided:

- **Gas Station –**
  - This category would include stand alone gas stations and gas station/convenience stores.

- **Multi-Family –**
  - This category would include community on-site systems serving apartments/townhouses, mobile home parks, and other residential developments such as condominiums and subdivisions.

For Residential systems: Indicate the dwelling type and size.

For either Non-Residential or Residential systems, the following applies:

Septic Tank Type: Indicate the type of tank arrangement providing the primary treatment (excluding any separate pumping or dosing tanks) or the complete absence of a tank.

Septic Tank Capacity – Gallons: Indicate the total volume of the tank(s) that provide the primary treatment (excluding any separate pumping or dosing tanks).

Advanced Treatment Unit: Indicate the presence or absence of an advanced treatment unit as a component to the failed system. Provide the name of the treatment unit when present.

System Design: Indicate the type of design of the failed system when determined or if available. If no information is available, or if efforts are undertaken to locate the system at the site, such as using a tile probe or soil auger and a system is located, however the specific design

cannot be determined, indicate "Unable to Determine". If it is determined that the there is no system; such as a tile to a ditch or field tile or other nonexistent system, indicate "None".

Note: Whenever "None" is indicated, completion of the remainder of the form is optional.

System Age: Indicate the age of the failed system as appropriate. If no information is provided or available as to the system age, indicate "Unknown".

Soil Texture: indicate only the soil texture representative of the infiltrative surface of the failed system. Do not report multiple soil textures representative of a typical soil profile description. In instances where there is no soil absorption system as noted above in "System Design", ""None", the reporting of soil texture is optional.

Seasonal High Water Table: Indicate the depth of seasonal high water table representative of location of the failed system, based upon the natural ground surface.

System Size: Indicate the size of the failed system when determined or if available. If no information is available from any source, indicate "Unable to Determine".

Probable Cause(s) of Failure: Indicate all elements believed to be contributing to the cause of the failure.

Note: If desired, it is acceptable for individual county or district health departments modifying their agency's data collection form and agency guidance to capture a single, predominant cause for failure in lieu of reporting multiple causes as long as the agency is capable of generating the annual data summary consistent with the DEQ failed system data collection elements.

In recognition for further guidance, the following examples are provided:

- **Hydraulic Overload –**
  - The system is receiving large quantities of ground water or surface water (could include; footing/foundation drainage via a sump pump or discharges from a water softener)
  - The design of the failed system was for a two-bedroom house, however, it is determined that the number of occupants is well beyond two people per bedroom.
- **System Undersized –**
  - The size of the failed system was based on site limitations such as insufficient space based on soils and/or space limitations.
- **Soil Clogging –**
  - The failed system is longer accepting wastewater effluent and the failure is reflective of a system that has functioned as designed during its normal life expectancy.

Section VI: On-Site Wastewater Treatment Management

DEQ Failed System Data Submission Form – Non-Residential

Calendar Year:

Local Health Department:

Total number of Non-Residential failures:

Facility Type; Totals:

Church | Dental/Medical | Gas Station | Grocery Store

Industrial | Multi-Family | Office/Retail | Restaurant

School

Other:_____

Estimated Flows; Totals:
(gallons per day)

<1,000 | >1,000 – 6,000 | >6,001 – 10,000 | >10,000

Septic Tank Type; Totals:

Single | Two Compartment | More Than One Tank | No Tank

Septic Tank Capacity – Gallons; Totals:

<1,000 | >1,000 – 1,500 | >1,500 – 2,000 | >2,000 – 3,000

>3,000 | Unknown

Advanced Treatment Unit; Totals Yes | No

If yes, Treatment Unit Name(s): _____

_____

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

System Design; Totals:

- ☐ Gravity Bed
- ☐ Dosed Bed
- ☐ Pressure Dosed Bed
- ☐ Gravity Trenches
- ☐ Dosed Trenches
- ☐ Pressure Dosed Trenches
- ☐ Gravity Mound
- ☐ Dosed Mound
- ☐ Pressure Dosed Mound
- ☐ Chambers
- ☐ Drywells
- ☐ None
- ☐ Other _____
- ☐ Unable to Determine

System Age Totals in Years; Totals:

- ☐ 0 – 5
- ☐ 6 – 10
- ☐ 11 – 15
- ☐ 16 – 20
- ☐ 21 – 25
- ☐ 26 – 30
- ☐ 31 – 40
- ☐ > 40
- ☐ Unknown

Soil Texture Totals:

- ☐ Coarse Sand, Medium Sand
- ☐ Fine Sand, Loamy Sand
- ☐ Sandy Loam
- ☐ Loam, Sandy Clay Loam
- ☐ Clay Loam, Silt Loam
- ☐ Clay, Silt
- ☐ Organic soil, Fill soil

Seasonal High Water Table; Totals:
(inches below grade)

- ☐ 0 – 12
- ☐ 13 – 24
- ☐ 25 - 36
- ☐ 37 – 48
- ☐ > 48

Bed Size ft²; Totals:

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

☐ 100 – 300	☐ 301 – 500	☐ 501 – 700	☐ 701 – 900
☐ 901 – 1100	☐ 1101 – 1300	☐ 1301 – 1500	☐ 1501 – 1700
☐ 1701 – 1900	☐ 1901 – 2100	☐ > 2100	☐ Unable to Determine

Trench Size ft²; Totals:

☐ 100 – 300	☐ 301 – 500	☐ 501 – 700	☐ 701 – 900
☐ 901 – 1100	☐ 1101 – 1300	☐ 1301 – 1500	☐ 1501 – 1700
☐ 1701 – 1900	☐ 1901 – 2100	☐ > 2100	☐ Unable to Determine

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

Probable Cause(s) of Failure; Totals:

☐ Septic Tank Failure ☐ Infrequent Tank Pumping ☐ Pipe Filled with Solids

☐ Damaged/Collapsed Piping System ☐ Hydraulic Overload ☐ System Undersized

☐ Insufficient Isolation to Water Table ☐ Root Intrusion ☐ Installation Error

☐ Unsuitable Fill ☐ Dirty Stone ☐ Excess Cover

☐ Lack of Maintenance ☐ Soil Clogging ☐ Unable to Determine

☐ Other: _____

Section VI: On-Site Wastewater Treatment Management

DEQ Failed System Data Submission Form – Residential

Calendar Year:

Local Health Department:

Total number of Residential failures:

Dwelling Type; Totals:

Single Family Two-Family

Dwelling Size; Totals:

2 Bedrooms 3 Bedrooms 4 Bedrooms >4 Bedrooms

Septic Tank Type; Totals:

Single Two Compartment More Than One Tank No Tank

Septic Tank Capacity – Gallons; Totals:

<1,000 >1,000 – 1,500 >1,500 – 2,000 >2,000 – 3,000

>3,000 Unknown

Advanced Treatment Unit; Totals Yes No

If yes, Treatment Unit Name(s): _____

_____

System Design; Totals:

Gravity Bed Dosed Bed Pressure Dosed Bed

Gravity Trenches Dosed Trenches Pressure Dosed Trenches

Gravity Mound Dosed Mound Pressure Dosed Mound

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

☐ Chambers ☐ Drywells ☐ None

☐ Other _____ ☐ Unable to Determine

System Age Totals in Years; Totals:

☐ 0 – 5 ☐ 6 – 10 ☐ 11 – 15 ☐ 16 – 20

☐ 21 – 25 ☐ 26 – 30 ☐ 31 – 40 ☐ > 40

☐ Unknown

Soil Texture Totals:

☐ Coarse Sand, Medium Sand ☐ Fine Sand, Loamy Sand ☐ Sandy Loam

☐ Loam, Sandy Clay Loam ☐ Clay Loam, Silt Loam ☐ Clay, Silt

☐ Organic soil, Fill soil

Seasonal High Water Table; Totals:
(inches below grade)

☐ 0 – 12 ☐ 13 – 24 ☐ 25 - 36 ☐ 37 – 48 ☐ > 48

Bed Size ft²; Totals:

☐ 100 – 300 ☐ 301 – 500 ☐ 501 – 700 ☐ 701 – 900

☐ 901 – 1100 ☐ 1101 – 1300 ☐ 1301 – 1500 ☐ 1501 – 1700

☐ 1701 – 1900 ☐ 1901 – 2100 ☐ > 2100 ☐ Unable to Determine

Trench Size ft²; Totals:

For technical assistance, please contact Ric Falardeau at 517-241-1345 or Dale Ladouceur at 517-241-1348.

Section VI: On-Site Wastewater Treatment Management

100 – 300	301 – 500	501 – 700	701 – 900
901 – 1100	1101 – 1300	1301 – 1500	1501 – 1700
1701 – 1900	1901 – 2100	> 2100	Unable to Determine

Section VI: On-Site Wastewater Treatment Management

Probable Cause(s) of Failure; Totals:

☐ Septic Tank Failure ☐ Infrequent Tank Pumping ☐ Pipe Filled with Solids

☐ Damaged/Collapsed Piping System ☐ Hydraulic Overload ☐ System Undersized

☐ Insufficient Isolation to Water Table ☐ Root Intrusion ☐ Installation Error

☐ Unsuitable Fill ☐ Dirty Stone ☐ Excess Cover

☐ Lack of Maintenance ☐ Soil Clogging ☐ Unable to Determine

☐ Other: _____

Section VI: On-Site Wastewater Treatment Management

Appendix E

On-Site Wastewater Treatment Management Program
Self-Assessment Review Option

Michigan local health departments (LHDs), in partnership with the Department of Environmental Quality (DEQ), are committed to the protection of public health and the environment through the effective On-Site Wastewater Treatment Management Programs. Structured evaluations of LHDs by DEQ staff on a 3-year basis, as part of the Michigan Local Public Health Accreditation Program (MLPHAP), have been utilized to measure the success of programs in meeting minimum program requirements (MPRs). Historical reviews clearly confirm that a commitment to ongoing quality assurance at LHDs have consistently resulted in accreditation reviews where there were few, if any, major deficiencies noted. It is the purpose of this guidance to establish the alternative option for accreditation review based upon annual LHD self-assessment and reporting which effectively communicates ongoing compliance status.

A significant component to the success of a self-assessment approach is the designation at the LHD of a key staff person or persons responsible for program training, oversight and monitoring. They would be relied upon as the in-house expert related to program implementation consistent with the MPRs and ongoing quality assurance monitoring. Designated staff would also be expected to serve as the primary point of communication and reporting to DEQ in all matters related to accreditation specific to the On-Site Wastewater Treatment Management Program. This would include submission of annual self-assessment reports, failed system data summaries, and quarterly on-site wastewater program activity reports.

All LHDs are encouraged to utilize the self-assessment approach. However, a LHD best prepared to use this option is conducting thorough routine and ongoing quality assurance program reviews. For LHDs wishing to be authorized to utilize this approach, a written request must be submitted to the DEQ for a case-by-case review. The quality assurance process, designed to meet LHD needs, is expected to be outlined by the LHD in the written request to the DEQ. At the time of the scheduled accreditation review, the LHD must be prepared to discuss the specific activities being carried out.

Local health departments desiring to utilize the self-assessment option are encouraged to submit their request as soon as possible. The self-assessment review option becomes stand alone where a LHD has requested and been granted DEQ authorization at least 12 months prior to the scheduled accreditation review date.

Under this option, the overall accreditation review shall consist of the following elements:

- Annually, the LHD is expected to submit a program self-assessment to the DEQ. The report will follow a standardized format that is available from the DEQ. Annual assessments shall be transmitted each year to the DEQ in the same month as the scheduled accreditation review.
- The DEQ will be responsible for providing a timely review and provide a formal response to the LHD for each self assessment report submitted.
- As part of the ongoing self-assessment process, during the time period leading to the scheduled accreditation review by the DEQ, a LHD may determine that one or more indicators are "not being met" or "met with conditions." The LHD has full discretion to:
    - Put a corrective plan of action in place, the details of which shall be communicated with the DEQ.
    - Show 90 days of compliance with the plan.

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- At the time of the scheduled accreditation review, the LHD shall receive a "met" or "met with conditions" on that MPR where the DEQ verifies corrective actions have resulted in compliance.

- At the time of the scheduled accreditation review, the LHD will arrange to meet with the DEQ to present documentation outlining the On-Site Wastewater Treatment Management Program's compliance. It is anticipated that the presentation would be arranged at a time, date, and location selected by the LHD and attended by the evaluator, designated LHD quality assurance staff, and others chosen by the LHD. Discussions at that time would focus on:
    - Quality assurance activities
    - Self-assessment and compliance rating against established program standards. At the time of the scheduled accreditation review, the current year self-assessment document will be presented to the DEQ by the LHD staff to verify that the self-assessment was completed accurately and properly.
        - The LHD will receive the rating it gave itself on any MPRs, providing the DEQ verifies the rating as correct.
        - Should a LHD assess any indicators as "not met," which are verified at the time of accreditation review, they will be subject to the established formal accreditation Corrective Plan of Action process.
        - Should the self-assessment show an incorrect rating or a program element that was not properly or completely reviewed, that element shall be jointly reviewed with the DEQ and LHD staff to determine the correct rating.
        - The DEQ may review a number of the original documents assessed to determine if the self-assessment is correct and accurate.

Section VII: HIV, AIDS & STD Categorical Funding

All indicators listed below are required, i.e., are essential for the agency to meet in order to pass each section of the accreditation review.

MPR 1

Perform activities necessary to control the spread of HIV and STD infection; conduct reporting and follow-up of HIV, AIDS and STD cases.

Reference: *PA 368 of 1978, MCL 333.5114, MCL 333.5131;* MCL 333.5201; MCL 333.5203*; PA 514 of 2004.*

Indicator 1.1

Reporting of HIV, AIDS, and STD cases are in compliance with the Michigan Communicable Disease Rules, and the Michigan Public Health Code.

This indicator may be met by:

Timely and appropriate submission of HIV, AIDS, and STD case reports.

Documentation Required:

- Copies of completed HIV, AIDS and STD case report forms or evidence of electronic submission within the Michigan Disease Surveillance System or the HIV, AIDS Reporting System.
- Locally developed protocol and procedures for completion and submission of case reports.
- Evidence (e.g., meeting minutes, sign in sheets) that staff with responsibility for case reporting has received orientation and training to policies and procedures regarding submission of case reports.

Evaluation Question:

Are all HIV, AIDS, and STD cases reported in compliance with Michigan Communicable Disease Rules and the Michigan Public Health Code?

Indicator 1.2

The confidentiality of written and electronic HIV, AIDS and STD reports and associated patient medical records are maintained in compliance with the Michigan Public Health Code, the Health Insurance Portability and Accountability Act (HIPAA), and program standards issued by the Michigan Department of Community Health.

This indicator may be met by:

Maintaining confidentiality of all HIV, AIDS and STD reports, records and data pertaining to HIV and STD testing, treatment and reporting, pursuant to the Michigan Public Health Code and HIPAA.

For technical assistance, please contact Bob Barrie 517-241-5934 or barrier@michigan.gov

Section VII: HIV, AIDS & STD Categorical Funding

Documentation Required:

- A locally developed written protocol that addresses HIV, AIDS and STD case reporting and medical record confidentiality.
- Evidence that staff have received and implemented appropriate orientation and training on confidentiality protocol and procedures.

Evaluation Questions:

- Is the confidentiality of case reports and client medical records protected pursuant to the Michigan Public Health Code, program standards issued by MDCH, and HIPAA?
- Does the local health department have written procedures that address HIV, AIDS and STD client privacy?

Indicator 1.3

The local health department investigates and responds to health threats to others, pursuant to the Michigan Public Health Code.

This indicator may be met by:

Conducting activities to investigate and respond to health threats to others in a way that is appropriate to the situation as specified in the report.

Documentation Required:

- A locally developed written protocol and procedures for investigating and responding to health threat to others and duty to warn circumstances.
- Evidence that staff have received and implemented appropriate orientation and training on protocol and procedures for investigating and responding to health threat to others and duty to warn circumstances.

Evaluation Question:

How are the local health jurisdiction's responsibilities carried out with regard to investigating and responding to health threat to others situations?

Section VII: HIV, AIDS & STD Categorical Funding

MPR 2

Provide HIV and STD screening and treatment.

Reference: *PA 57 of 1998, MCL 333.5204; MCL 333.5207; PA 368 of 1978, MCL 333.5129, MCL 333.5133; Quality Assurance Standards for HIV Prevention Interventions, MDCH (2003).*

Indicator 2.1

Provide HIV and STD screening and treatment services in accordance with the Michigan Public Health Code and MDCH accreditation and quality assurance standards.

This indicator may be met by:

- Implementing recruitment and promotional strategies designed to increase awareness and stimulate testing among high risk individuals.
- Assessing client risk for HIV and other STDs.
- Providing risk reduction/prevention counseling for all clients with risk for HIV and STDs.
- Providing STD testing in accordance to client risk and MDCH criteria.
- Providing appropriate STD treatment.
- Providing HIV testing for all clients screened and/or treated for sexually transmitted diseases.
- Providing STD testing for clients testing positive for HIV.

Documentation Required:

- Press releases, flyers and/or other evidence of recruitment and promotional activities.
- Written clinic-specific protocol and procedures for provision of HIV and STD screening and clinical services. Protocol and procedures **MUST** address:
    - Timely admission, examination and treatment of clients presenting for HIV and STD services;
    - Assessment of client risk for HIV and STDs;
    - Criteria for prioritizing clients for HIV and STD screening;
    - Appropriate STD treatment;
    - Routine provision of HIV testing for clients screened and/or treated for STDs;
    - Provision of STD testing for clients testing positive for HIV;
    - Provision of risk reduction and prevention counseling;
    - Follow up for disclosure of test results for clients who do not complete return clinic visits.
- Client medical charts include risk reduction plans for all clients and treatment referrals for clients diagnosed with HIV infection.

For technical assistance, please contact Bob Barrie 517-241-5934 or barrier@michigan.gov

Section VII: HIV, AIDS & STD Categorical Funding

- Written protocols and procedures for provision of anonymous HIV testing.
- Evidence that all staff have received orientation/training on clinic protocol and procedures.

Evaluation Questions

- Are HIV and STD clinical and prevention services responsive to Michigan Public Health Code, MDCH accreditation and MDCH quality assurance standards?
- What recruitment and promotional strategies are used to promote awareness of services and to stimulate STD and HIV testing among high risk populations?

Indicator 2.2

Provide court ordered STD and HIV counseling, testing and referral services and victim notification activities in accordance with the Michigan Public Health Code, Sec. 333.5129 and MDCH guidance.

This indicator may be met by:

Providing STD and HIV counseling, testing and referral services on the basis of court order and for notification of victims.

Documentation Required:

- Written protocols and procedures for providing or arranging for the provision of court ordered STD and HIV counseling, testing and referral services and victim notification.
- Evidence that staff have received orientation and training on the policies and procedures.

Evaluation Question:

Are court-ordered STD and HIV counseling, testing and referral services and victim notification services provided in accordance with the Michigan Public Health Code and MDCH guidelines?

Section VII: HIV, AIDS & STD Categorical Funding

MPR 3

Develop and maintain a system for staff-assisted referral of clients to medical and other prevention services, including mechanisms for monitoring and documenting completed referrals.

References: *PA 368, Part 51 of 1978, MCL 333.5111, MCL 333.5114a; and Quality Assurance Standards for HIV Prevention Interventions, MDCH (2003).*

Indicator 3.1

Clients diagnosed with HIV or other STDs receive medical and other prevention services appropriate and responsive to their needs and responsive to MDCH program standards and guidelines.

This indicator may be met by:

Facilitating referral to and linkage with prevention, treatment and support services appropriate to and responsive to client needs.

Documentation Required:

- Written referral and linkage protocol and procedures which address:
  - Assessment and prioritization of client needs for prevention, treatment and other services;
  - Provision of, or referral to, other prevention services (e.g., substance abuse disorder treatment)
  - Provision of assisted referral to specialty medical care for clients diagnosed with HIV in order to evaluate and treat HIV infection;
  - Provision of or referral to partner services for clients diagnosed with HIV and/or syphilis;
  - Provision of screening for STD, especially syphilis, gonorrhea, and chlamydia, among clients diagnosed with HIV;
  - For HIV clients, confirmation of referral completion. Successful linkage with partner services and medical specialty care for HIV infected clients is prioritized.
- Evidence that staff has received orientation and training on facilitated referrals.
- A current community resources referral directory. The directory should provide staff with specific information regarding services, eligibility, agency contacts and other information necessary for staff to make and support successful referrals.
- Evidence of relationships, e.g., memoranda of understanding or agreement, with other service providers that facilitate successful referrals.

Evaluation Questions:

- Are clients diagnosed with HIV and other STDs able to be successfully linked to needed medical and prevention services?
- Are referral strategies for HIV-infected persons provided in accordance with MDCH quality assurance standards?

For technical assistance, please contact Bob Barrie 517-241-5934 or barrier@michigan.gov

Section VII: HIV, AIDS & STD Categorical Funding

- Are referrals made appropriate to addressing the needs of clients and in accordance with MDCH quality assurance standards?

Section VII: HIV, AIDS & STD Categorical Funding

MPR 4

Conduct partner services (PS) for HIV, gonorrhea and chlamydia.

***References**: PA 489 of 1988 and PA 86 of 1992, MCL 333.5111; MCL 333.5114a; Michigan Administrative Code R 325.177.*

Indicator 4.1

Individuals diagnosed with HIV, gonorrhea, and/or chlamydia receive counseling regarding the availability of partner services and are offered assistance in notifying their sex and/or needle-sharing partners of their exposure.

This indicator may be met by:

- Providing partner services that are responsive to client needs and are provided in accordance with the Michigan Public Health Code and MDCH standards and guidelines.
- Maintaining staffing adequate to meet PS needs.
- Maintaining relationships, for example, via memoranda of understanding/agreement (MOU/MOA), with health care providers, community-based organizations and other that provide HIV and STD testing in order to facilitate access to health department assisted PS among clients diagnosed with HIV and other STDs.

Documentation Required:

- Written PS protocol and procedures that addresses:
    - Criteria and procedures for prioritizing index clients and partners and associates pursuant to MDCH standards and guidelines;
    - Field investigations;
    - Use of electronic, social media, and other communication strategies for notifying partners (including client notification of partners);
    - Provision of or referral for screening for HIV and STD
    - Provision of risk reduction/prevention counseling;

- Written policies to enable and support PS staff to work a flexible schedule outside the confines of the local health department.

- Medical charts of clients diagnosed with HIV include documentation of counseling about health department assisted partner services.

- Evidence that staff with responsibility for PS has received orientation/training and maintain necessary certifications.

- Evidence of mechanisms and practices that facilitate efficient communication about PS with health care providers, community based organizations and other providers of HIV and STD testing services. For example, these might include copies of letters, MOAs/MOUs, breakfast meetings with key staff from the local health department and area providers.

Section VII: HIV, AIDS & STD Categorical Funding

Evaluation Questions:

- Are PS activities responsive to Michigan Public Health Code and MDCH guidance?
- What strategies and tools are used to facilitate client self-notification of partners?
- What strategies and tools are used to facilitate notification of anonymous partners?

Section VII: HIV, AIDS & STD Categorical Funding

MPR 5

Provide quality assured and evidence-based HIV and STD prevention and treatment services.

References: *PA 368 of 1978, MCL 333.2433, MCL 333.5111 (Michigan Administrative Code, R 325.171, R 325.172, R 325.173, R 325.174, R 325.177, and R 325.181), MCL 333.5115, MCL 333.5201 – MCL 333.5209; and MCL 722.623; CDC Program Operations Guidelines for STD Prevention, Surveillance and Data Management (2001); Quality Assurance Standards for HIV Prevention Interventions, MDCH (2003).*

Indicator 5.1

Monitor and evaluate HIV and STD prevention and treatment services.

This indicator may be met by:

Conducting routine, data-driven monitoring and evaluation activities.

Documentation Required:

- Written policies and procedures that address the collection, management and reporting of client level data essential for, and required by MDCH for program monitoring and evaluation.
- Evidence that required data are collected and reported pursuant to guidelines issued by the MDCH.
- Evidence that staff with responsibility for collection and entry of client level data have received orientation to and training on the data collection and management procedures.
- Evidence that data are routinely applied to program monitoring and evaluation activities, for example, use of trend data to trigger adjustment in outreach activities, case conferencing that allows for coordinated prevention activities, or performance indicators informing staff assignments.

Evaluation Questions:

None

Indicator 5.2

Provide quality assurance of HIV and STD prevention and treatment services.

This indicator may be met by:

Conduct routine quality assurance of HIV and STD prevention and treatment services responsive to MDCH quality assurance standards and guidelines.

Section VII: HIV, AIDS & STD Categorical Funding

Documentation Required:

- Written protocols and procedures for quality assurance activities associated with provision of HIV and STD prevention and treatment services. Protocol and procedures must address methods to regularly address staff competency and performance.
- Evidence of use of multiple strategies to conduct agency-developed quality assurance.
- Evidence that staff has participated in quality assurance activities.
- Evidence that staff have received training and orientation to protocols and procedures associated with provision of HIV and STD prevention and treatment services.
- Evidence that staff has successfully completed required training and/or certification requirements associated with the provision of HIV and STD prevention and treatment services.
- Evidence that supervisors and staff have participated in training and professional development activities designed to improve their capacity to provide high quality HIV and STD prevention and treatment services.
- Evidence of completion and timely submission of quality assurance reports, pursuant to guidance issued by MDCH including, rapid test quality assurance logs, and STD Quarterly Activity and Medication Inventory Reports.

Evaluation Question:

Are quality assurance activities routinely conducted and responsive to MDCH issued quality assurance standards and guidelines?

Section VII: HIV, AIDS & STD Categorical Funding

MPR 6

Establish, maintain and document linkages with health care and other community resources that are necessary and appropriate for the prevention and control of HIV and other STDs; and for addressing the prevention and care needs of clients receiving HIV and STD services.

Reference: *PA 368 of 1978, MCL 333.5114, MCL 333.5131;* MCL 333.5201; MCL 333.5203*;* *PA 514 of 2004,* Michigan, *Administrative Code R325.174(1)(5); R325.173(7); Quality Assurance Standards for HIV Prevention Interventions, MDCH (2003).*

Indicator 6.1

HIV and STD case reporting are performed in accordance with the Michigan Public Health Code.

This indicator may be met by:

Provision of education and technical assistance to physicians, laboratories and other providers that addresses case reporting requirements and mechanisms.

Documentation Required:

- Evidence of dissemination of the agency's annual report that addresses HIV, AIDS and STD morbidity and mortality including trends.
- Evidence of provision of technical assistance and education that addresses case reporting.

Evaluation Question:

What practices are regularly conducted to ensure timely and appropriate reporting of case reports from local providers?

Indicator 6.2

Individuals with undiagnosed infection with HIV and/or other STDs served by non-health department entities learn their status and are linked with appropriate medical, prevention and support services.

This indicator may be met by:

Provision of education and technical assistance to local physicians, hospitals, other providers and community groups to increase awareness about HIV and other STDs, encourage screening for and treatment of HIV and STDs, support referral and linkages to needed services, and promote health department assisted partner services.

Documentation Required:

- Evidence of a data-driven jurisdiction-wide provider and community education plan.
- Evidence of provision of education and technical assistance to local providers, including the topic areas covered and target audience.

For technical assistance, please contact Bob Barrie 517-241-5934 or barrier@michigan.gov

Section VII: HIV, AIDS & STD Categorical Funding

Evaluation Questions:

- What activities are undertaken to promote and support increased screening by physicians, hospitals, community health centers and other providers?
- What activities are undertaken to support referral and linkage to prevention and treatment services?
- What activities are undertaken to promote and encourage use of local health department assisted partner services?

Indicator 6.3

Client prevention, treatment and support needs are addressed through a diverse range of community resources.

This indicator may be met by:

Establishing and maintaining active linkages with key community resources.

Documentation Required:

- Evidence of a current community resource directory.
- Evidence and description of active relationships with key community resources (e.g., memoranda of agreements, meeting agendas and minutes).

Evaluation Questions:

- Does the health department maintain active relationships with other providers/organizations?
- Are these relationships relevant and appropriate to addressing client needs for prevention, treatment and support services?

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

MPR 1

Perform activities necessary to control the spread of HIV and STD infection; conduct reporting and follow-up of HIV, AIDS and STD cases.

Reference: *PA 368 of 1978, MCL 333.5114, MCL 333.5131;* MCL 333.5201; MCL 333.5203; *Michigan Administrative Code R 325.181*; PA *514 of 2004.*

Indicator 1.1

Reporting of HIV, AIDS, and STD cases are in compliance with the Michigan Communicable Disease Rules, and the Michigan Public Health Code.

This indicator may be met by:

Timely and appropriate submission of HIV, AIDS, and STD case reports.

Documentation Required:

- Copies of completed HIV, AIDS and STD case report forms or evidence of electronic submission within the Michigan Disease Surveillance System or the HIV/AIDS Reporting System.
- Locally developed protocol and procedures for completion and submission of case reports.
- Evidence that staff with responsibility for case reporting have received orientation and training to policies and procedures regarding submission of case reports.

Evaluation Question:

Are all HIV, AIDS, and STD cases reported in compliance with Michigan Communicable Disease Rules and the Michigan Public Health Code?

Indicator 1.2

The confidentiality of written and electronic HIV, AIDS and STD reports and associated patient medical records are maintained in compliance with the Michigan Public Health Code, the Health Insurance Portability and Accountability Act (HIPAA), and program standards issued by the Michigan Department of Community Health.

This indicator may be met by:

Maintaining confidentiality of all HIV, AIDS and STD reports, records and data pertaining to HIV and STD testing, treatment and reporting, pursuant to the Michigan Public Health Code and HIPAA.

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

Documentation Required:

- A locally developed written protocol that addresses HIV, AIDS and STD case reporting and medical record confidentiality.
- Evidence that staff have received and implemented appropriate orientation and training about confidentiality protocols and procedures.

Evaluation Questions:

- Is the confidentiality of case reports and client medical records protected pursuant to the Michigan Public Health Code, program standards issued by MDCH, and HIPAA?

- Does the local health department have written procedures that address HIV, AIDS and STD client privacy?

Indicator 1.3

The local health department investigates and responds to health threats to others, pursuant to the Michigan Public Health Code.

This indicator may be met by:

Conducting activities to investigate and respond to health threats to others.

Documentation Required:

- A locally developed written protocol and procedures for investigating and responding to health threat to others and duty to warn circumstances.

- Evidence that staff have received and implemented appropriate orientation and training on protocol and procedures for investigating and responding to health threat to others and duty to warn circumstances.

Evaluation Question:

How are the local health jurisdiction's responsibilities carried out with regard to investigating and responding to health threat to others situations?

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

MPR 2

Provide HIV and STD screening and treatment.

Reference: *PA 57 of 1998, MCL 333.5204; MCL 333.5205; MCL 333.5207; PA 368 of 1978, MCL 333.5114; MCL 333.5129, MCL 333.5133; ; Michigan Administrative Code R 325.177(2); Quality Assurance Standards for HIV Prevention Interventions, MDCH(2003).*

Indicator 2.1

Provide HIV and STD screening and treatment in accordance with the Michigan Public Health Code and MDCH accreditation and quality assurance standards.

This indicator may be met by:

Provide and/or refer clients for HIV and STD screening and treatment.

Documentation Required:

- Written clinic-specific protocol and procedures for provision of HIV and STD screening and clinical services, on-site or through referral.
- Evidence that all staff have received orientation/training on clinic protocol and procedures.
- For clients diagnosed with HIV, evidence of referral plans in client charts and documentation of completed referrals.
- A current community resources referral directory.
- Evidence of relationships with other service providers that facilitate successful referrals.

Evaluation Questions:

- Are HIV and STD prevention and clinical services responsive to the Michigan Public Health Code and MDCH accreditation and quality assurance standards?
- Are referrals made appropriate to addressing the needs of clients and in accordance with MDCH quality assurance standards?

Indicator 2.2

Provide court ordered STD and HIV counseling, testing and referral services and victim notification activities in accordance with the Michigan Public Health Code and MDCH guidance.

Section VII: HIV, AIDS & STD
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This indicator may be met by:

Providing STD and HIV counseling, testing and referral services on the basis of court order and for notification of victims.

Documentation Required:

- Written protocols and procedures for providing or arranging for the provision of court ordered STD and HIV counseling, testing and referral services and victim notification.
- Evidence that staff have received orientation and training on the policies and procedures.

Evaluation Question:

Are court-ordered STD and HIV counseling, testing and referral services and victim notification services provided in accordance with the Michigan Public Health Code and MDCH guidelines?

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

MPR 3

Facilitate by referral and coordination with MDCH provision of partner services (PS) for HIV and syphilis. Provide partner services for gonorrhea and chlamydia, as resources allow.

References: *PA 489 of 1988 and PA 86 of 1992 MCL 333.5111; MCL 333.5114a; Michigan Administrative Code R 325.177; and Recommendations for Conducting Partner Services in the Prevention of HIV/STDs, MDCH (2011).*

Indicator 3.1

Individuals diagnosed with HIV, gonorrhea and/or chlamydia receive counseling regarding the availability of partner services and are offered assistance in notifying their sex and/or needle-sharing partners of their exposure.

This indicator may be met by:

Providing partner services in accordance with the Michigan Public Health Code and MDCH standards and guidelines.

Maintaining relationships with health care providers, community-based organizations and others that provide HIV and STD testing in order to facilitate access to health department assisted PS among clients diagnosed with HIV and other STDs.

Documentation Required:

- Written PS protocol and procedures that addresses:
  - Referral to and coordination with MDCH for HIV and syphilis
  - Criteria and procedures for prioritizing index clients and partners and associates pursuant to MDCH standards and guidelines;
  - Investigations;
  - Use of electronic, social media, and other communication strategies for notifying partners;
  - Provision of or referral for screening for HIV and STD
  - Provision of risk reduction counseling;
- Medical charts of clients of clients diagnosed with HIV include documentation of counseling about health department assisted partner notification.
- Evidence that staff with responsibility for PS has received orientation/training and maintain necessary certifications.
- Evidence of mechanisms and practices that facilitate efficient communication about PS with health care providers, community based organizations and other providers of HIV and STD testing services.

Evaluation Questions:

- Are PS activities responsive to Michigan Public Health Code and MDCH guidance?
- What strategies and tools are used to facilitate client self-notification of partners?
- What strategies and tools are used to facilitate notification of anonymous partners?

For technical assistance, please contact Bob Barrie 517-241-5934 or barrier@michigan.gov

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

MPR 4

Establish, maintain and document linkages with health care and other community resources that are necessary and appropriate for the prevention and control of HIV and other STDs; and for addressing the prevention and care needs of clients receiving HIV and STD services.

Reference: *Michigan Administrative Code R325.174(1)(5); R325.173(7); Recommendations for Conducting Partner Services in the Prevention of HIV/STDs, MDCH (2011).*

Indicator 4.1

Individuals with undiagnosed infection with HIV and/or other STDs served by non-health department entities learn their status and are linked with appropriate medical, prevention and support services.

This indicator may be met by:

Provision of education and technical assistance to local physicians, hospitals, other providers and community groups to increase awareness about HIV and other STDs, ensure accurate and timely case reporting, encourage screening for and treatment of HIV and STDs, support referral and linkages to needed services, and promote health department assisted partner services.

Documentation Required:

- Evidence of dissemination of a jurisdiction specific annual report that addresses HIV, AIDS and STD morbidity and mortality including trends.
- Evidence of a data-driven jurisdiction-wide community and provider education plan.
- Evidence of provision of education and technical assistance to local providers, including the topic areas covered and target audience.

Evaluation Questions:

- What activities are undertaken to ensure timely and appropriate reporting of case reports from local physicians, hospitals, laboratories and others?
- What activities are undertaken to promote and support increased screening by physicians, hospitals, community health centers and other providers?
- What activities are undertaken to support referral and linkage to prevention and treatment services?
- What activities are undertaken to promote and encourage use of local health department assisted partner services?

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

Indicator 4.2

Client prevention, treatment and support needs are addressed through a diverse range of community resources.

This indicator may be met by:

Establishing and maintaining active linkages with key community resources.

Documentation Required:

- Evidence of a current community resource directory.
- Evidence and description of active relationships with key community resources (e.g., memoranda of agreement, meeting agendas and minutes).

Evaluation Questions:

- Does the health department maintain active relationships with other providers/organizations?
- Are these relationships relevant and appropriate to addressing client needs for prevention, treatment and support services?

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

MPR 5

Provide quality assured and evidence-based HIV and STD prevention and treatment services.

References: *PA 368 of 1978, MCL 333.2433, MCL 333.5111 (Michigan Administrative Code, R 325.171, R 325.172, R 325.173, R 325.174, R 325.177, and R 325.181), MCL 333.5115, MCL 333.5201 – MCL 333.5209; and MCL 722.623; CDC STD Program Operations Guidelines for STD Prevention, Medical and Laboratory Services, 2001; CDC STD Treatment Guidelines, 2006; and Quality Assurance Standards for HIV Prevention Interventions, MDCH, 2003; and Recommendations for Conducting Partner Services in the Prevention of HIV/STDs, MDCH (2011).*

Indicator 5.1

Monitor and evaluate HIV and STD prevention and treatment services.

This indicator may be met by:

Conduct routine, data-driven monitoring and evaluation activities.

Documentation Required:

- Written policies and procedures that address the collection, management and reporting of client level data essential for and required by MDCH for program monitoring and evaluation.
- Evidence that required data are collected and reported pursuant to guidelines issued by the MDCH.
- Evidence that staff with responsibility for collection and entry of client level data have received orientation to and training on the data collection and management procedures.
- Evidence that data are routinely applied to program monitoring and evaluation activities.

Evaluation Questions:

None

Indicator 5.2

Provide quality assurance of HIV and STD prevention and treatment services.

This indicator may be met by:

Conduct routine quality assurance of HIV and STD prevention and treatment services responsive to MDCH quality assurance standards and guidelines.

Section VII: HIV, AIDS & STD
Low Morbidity Health Departments

Documentation Required:

- Written protocols and procedures for quality assurance activities associated with provision of HIV and STD prevention and treatment services. Protocol and procedures must address methods to regularly address staff competency and performance.
- Evidence that staff have participated in quality assurance activities.
- Evidence that staff have received training and orientation to protocols and procedures associated with provision of HIV and STD prevention and treatment services.
- Evidence that staff have successfully completed required training and/or certification requirements associated with the provision of HIV and STD prevention and treatment services.
- Evidence that supervisors and staff have participated in training and professional development activities designed to improve their capacity to provide high quality HIV and STD prevention and treatment services.
- Evidence of completion and timely submission of quality assurance reports, pursuant to guidance issued by MDCH including STD Quarterly Activity and Medication Inventory Reports.

Evaluation Question:

Are quality assurance activities routinely conducted in accordance with MDCH issued quality assurance standards and guidelines?

Section VIII: Vision

MPR 1

The local health department shall make available vision screening for preschool children between the ages of three and five years.

Reference: *Michigan Administrative Code, R 325.13094 (1).*

Indicator 1.1

There is a system in place to schedule children between the ages of 3 and 5 years for vision screening upon request.

This indicator may be met by:

The local health department maintains on file:

- A written policy or program plan articulating procedures for vision screening children between the ages of 3 and 5 years.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 1.2

Documentation of vision screening is on file for children between the ages of 3 and 5 years.

This indicator may be met by:

The local health department maintains on file:

- Individual child screening forms and an appointment book or agency calendar for the past year showing preschool children who were scheduled and received vision screening services.
- A list of names of preschool children who were referred to eye care practitioners.
- Copies of local health department quarterly batch sheets (Form DCH-0604) indicating the number of preschool children screened, passed, failed, referred and receiving care since the last accreditation site visit.
- A list of Head Start and child-care centers scheduled to receive vision screening services for the current year (unless screened through EPSDT).

Documentation Required:

See above.

For technical assistance, please contact Rachel Schumann at 517-335-6596 or schumannr@michigan.gov

Section VIII: Vision

Evaluation Question:

None

Section VIII: Vision

MPR 2

The local health department shall assure that school-age children receive vision screening in grades 1, 3, 5, 7, & 9 or grades 1, 3, 5, & 7, and in conjunction with driver training classes.

Reference: *Michigan Administrative Code R 325.13094 (2).*

Indicator 2.1

Program activity reports and statistics document the provision of vision screening in all private and public schools for all estimated children in need (e.g., total number of children in grades targeted for screening).

This indicator may be met by:

The local health department maintains on file:

- A chart or schedule documenting agency vision technician assignments and/or responsibilities for the current year.
- A written policy or program plan articulating the level of frequency for vision screening school-age children.
- A composite list of names of school-age children who were referred to eye care practitioners.

Copies of local health department quarterly batch sheets (Form DCH-0604) indicating the number of school-age children screened, passed, failed, referred and receiving care since the last accreditation site visit.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 3

The local health department shall screen preschool children in accordance with Section II of the Michigan Department of Community Health (MDCH) Vision Technician's Manual (Revised, 1/2006).

Reference: *Michigan Administrative Code R 325.13092.*

Indicator 3.1

A preschool screening instrument, tape measure, training cards, a black wooden block "E", or comparable orientation "E", penlight, near and far targets for the cover tests, and a flash card acuity test are available for the vision screening of children between the ages of 3 and 5 years.

This indicator may be met by:

The local health department has available:

1. Supplies and equipment used by vision technicians including a screening instrument, tape measure, training cards, black wooden "E", or comparable orientation "E", penlight, near and far targets for the cover tests, and a flash card acuity test necessary to perform preschool vision screening of children.

2. A functioning stereoscopic instrument for the screening of school-age children for monocular visual acuity, two-line difference acuity, near and far phorias and the plus lens test.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 4

Where follow-up treatment is required, the local health department shall assure that a written statement indicating the necessary course of action is provided to the parent or guardian of the child.

Reference: *PA 368 of 1978, MCL 333.9305 (1).*

Indicator 4.1

Documentation exists that written statements indicating the necessary course of action have been provided to parents or guardians of children whenever follow-up examination or treatment is necessary as a result of vision screening.

This indicator may be met by:

The local health department maintains on file:

DCH-0503 Room Summary Forms, or equivalents, confirming follow-up information on children referred to an eye care practitioner, and sample parent letters for inspection to confirm agency process for follow-up of children referred to an eye care practitioner.

Documentation Required:

See above.

Evaluation Question:

None

Indicator 4.2

Documentation demonstrates that a child referred for examination or treatment has received the recommended services.

This indicator may be met by:

The local health department maintains on file:

DCH-0503 Room Summary Forms, or equivalents, doctor's cards or letters confirming the follow-up of children referred to an eye care practitioner.

Documentation Required:

See above.

Section VIII: Vision

Evaluation Question:

None

Section VIII: Vision

MPR 5

The local health department shall assure that individuals administering the screening and testing are trained in accordance with curriculum approved by the MDCH.

Reference: *Michigan Administrative Code R 325.13093.*

Indicator 5.1

All vision technicians have been trained in accordance with curriculum approved by the Michigan Department of Community Health (MDCH), and that all vision technicians have attended an MDCH approved vision technician workshop once in the last two years.

This indicator may be met by:

The local health department maintains on file:

- Vision training certificates confirming that technicians have participated in the approved MDCH training course to become qualified to screen preschool and school-age children.
- Workshop certificates confirming that technicians have participated in the approved MDCH vision technician workshop once in the last two years.
- Appraisal forms to confirm the participation of the vision technicians in the State-developed Technician Assessment Program (TAP), where preschool screening procedures are observed and evaluated by an outside monitor with a minimum of at least 5 children, ages 3-5 years.
- Appraisal forms to confirm the participation of the vision technicians in the State-developed Technician Assessment Program (TAP), where school-age screening procedures are observed and evaluated by an outside monitor with a minimum of at least 5 children in grades 1,3,5,7 and 9.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 6

A local health department shall conduct periodic free vision programs for the testing and screening of children residing in its jurisdiction. The time and place of the programs shall be publicized.

Reference: *PA 368 of 1978, MCL 333.9301.*

Indicator 6.1

All vision screening services are provided to children without charge to parents or guardians.

This indicator may be met by:

The local health department maintains on file:

- Public announcements and media advertisement publicizing opportunities for scheduling preschool children for vision screening at local health departments.
- Documentation of public bulletins and public service announcements that include language indicating that free vision testing is available.
- An annual timetable for the purpose of notifying the public of vision screening dates, locations, and procedures for scheduling preschool children ages 3 through 5 years and school-age children in grades 1,3,5,7 and 9 (or in conjunction with driver's training).

Documentation Required:

See above.

Evaluation Question:

None

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Program Management

MPR 1

Coordinate with MDCH an annual review of minimum program and reporting requirements.

References: *PL 101-354, Section 1501 (a)(6); CDC Administrative Guidance; CPBC provision.*

Indicator 1.1

Requirements to continue screening services are met as evident from the annual site evaluation.

This indicator may be met by:

There must be evidence that the local health department is continuously meeting the CDC program requirements as outlined in each of the following categories: Program Management, Outreach and Recruitment, Coordination/Case Management of Clinical Care Delivery, Monitoring Reimbursement of Clinical Services, and Data Quality.

Documentation Requested:

None specifically for this indicator. This indicator is met as a result of scheduling the accreditation visit.

Evaluation Question:

None

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

MPR 2

Assure that an accurate and integrated system of fiscal management is maintained on-site for health departments providing clinical services; assure that a system of communication is maintained across all other sites of clinical service delivery.

References: *PL 101-354, Section 1504 (e); CDC Administrative Guidance.*

Indicator 2.1

A system of communication exists between local health department staff and BCCCP providers to enable accurate and timely processing of clinical service data, and to assure adequate provider training and support in resolving clinical and billing issues.

This indicator may be met by:

All of the following:

- The local health department either maintains on file OR has access to client information via an Electronic Medical Record the following: clinical data forms, screening/diagnostic test results, provider clinical/consultation notes, and insurance billing documentation **AND**
- The BCCCP Coordinator maintains on file a description of the required communications between BCCCP staff at the local health department and subcontracted provider staff; **AND**
- Written evidence of the local health department's process/procedure for gathering clinical service data from each BCCCP provider/clinic and verifying the accuracy of the data.

Documentation Requested:

- Description of the system the local health department uses to access client information as described under "this indicator may be met by".
- Description of the required communications between BCCCP staff at the local health department and subcontracted provider staff.
- Written policy outlining the procedure for gathering clinical service data from each BCCCP provider/clinic and verifying the accuracy of the data.

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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Evaluation Questions:

- Is there evidence of a system (e.g., flow chart, regular staff minutes, etc.) for routing information from MBCIS Data Forms and/or test results or copies of exam results to all appropriate individuals?
- Is there a description of the required communications (e.g., data form requirements, scheduled visits by the Coordinator, specific individual contacts, etc.) between BCCCP staff at the local health department and subcontracted provider staff maintained on file at the local health department?
- Is there a written policy outlining the procedure for gathering clinical service data?

Indicator 2.2

Evidence exists of processes for routine communications with providers who are part of the BCCCP delivery network, e.g., advisory committee proceedings, regular meetings with key providers, individually or in groups; key contact people identified throughout the BCCCP delivery network; and activities designed to increase general provider awareness of the BCCCP, for example distribution of packets and newsletters.

This indicator may be met by:

The local health department maintains on file evidence of routine communications through minutes from meetings, agendas, letters, email, correspondence, and faxes.

Documentation Requested:

Combination of the following should demonstrate routine communications such that all providers are contacted with program updates, opportunities to address provider concerns, and access to at least annual training for new staff:

- Agenda/minutes/membership of most recent provider/advisory meetings.
- Provider mailing list for BCCCP Newsletter.
- Correspondence/memos/phone calls to providers within the last 6 months.

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Indicator 2.3

The local health department has a policy that requires the review of provider licenses at the time of initial hire or contract; in the event of transfers or promotions upon individual attainment of a new level of provider license; and routinely at specified intervals for all local health department and subcontracted providers.

This indicator may be met by:

The local health department has a written policy on file that requires review of provider licenses: at the time of initial hire or contract; upon transfers or promotions upon individual attainment of a new level of provider license; and routinely at specified intervals for all local health department and subcontracted providers.

Documentation Requested:

Written policy stating that provider licenses are reviewed at specified intervals – as stated in "This indicator may be met by."

Evaluation Question:

Does the local health department have a written policy stating the procedure for review of provider licenses?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Outreach/Recruitment

MPR 3

Assure that there is community involvement with issues related to relationships with the medical community, resources for follow-up care, and recruitment of target populations.

References: *PL101-354, Sections 1501 (a)(3) and 1504 (a); CDC Administrative Guidance.*

Indicator 3.1

Evidence exists that recruitment and promotion efforts, and efforts to maintain and expand the BCCCP delivery network, are planned and implemented with involvement from the local ACS and community groups representing priority populations.

This indicator may be met by:

- The local health department maintains on file evidence that recruitment and promotion efforts are planned and implemented through PSAs, public awareness flyers, semi-annual newsletters, and information packets; **AND**
- Efforts to maintain and expand the BCCCP delivery network are planned and implemented through meeting minutes; increasing the number of providers and/or the number of providers is maintained.

Documentation Requested:

Combinations of the following that describes efforts to address provider concerns, increase provider awareness, and assure the satisfaction of providers with the program:

- Steering committee membership list.
- Steering committee/advisory meeting minutes from last 12 months.
- Other documentation of ACS or other community organization collaboration (i.e., advisory committee proceedings, phone calls, written correspondence, etc. are planned and implemented with involvement from the local ACS and community groups representing target populations).

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

MPR 4

Recruit women eligible for the BCCCP, giving priority to minorities and women aged 50 to 64 and women who have previously been screened through the BCCCP.

References: *PL 101-354, Sections 1501 (a)(3) and 1504 (a); CDC Administrative Guidance.*

Indicator 4.1

Recruit women eligible for the BCCCP based on program criteria for identifying target populations as defined by CDC. This includes women from the following categories:

1. Minority women (percentage recruited is based on women served in the local coordinating agency's jurisdiction).
2. Women age 50-64 (percentage recruited is based on CDC's program criteria).
3. Women never or rarely screened for cervical cancer (> 20% of NEWLY enrolled women in the program are those who have never had a Pap test or not had a Pap test in >/= 5 years.

This indicator may be met by:

A plan exists to recruit target populations of women as defined above into the local BCCCP. The local coordinating agency must describe verbally or in writing how they:

- Ensure they are serving individual minority populations (at a percentage equal to or higher than the percentage of individual minority populations represented in the local coordinating agency's jurisdiction) by comparing data from the MDCH/Cancer Prevention and Control Section BCCCP database with the current demographic information;
- Identify and recruit priority women (age 50-64) to comply with caseload ratios determined by MDCH and CDC; **AND**
- Identify and recruit women never or rarely screened in the program as defined by CDC.

Documentation Requested:

ALL of the following:

- Current demographic information (e.g., census data) indicating the percentage of individual minority populations in the local health department's jurisdiction;
- Data from the BCCCP database indicating the percentage of BCCCP clients from the individual minority populations; **AND**

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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- Evidence that the agency has used and compared data from the BCCCP database with the current demographic information to ensure that it serves individual minority populations at a percentage equal to or higher than the percentage of individual minority populations represented in the local health department's jurisdiction.

Evaluation Question:

Has the local health department provided the information specified (verbal or written) required for the evaluation?

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Coordination/Case Management of Clinical Care Delivery

MPR 5

Assure that screening and follow-up services meet minimum state/federal requirements as specified for: a.) Mammography facilities, b.) Michigan licensed: Physicians, Certified Nurse Practitioners, Certified Nurse Midwives, or Physician Assistants, c.) Adherence to the BCCCP Medical Protocol.

References: *PL 101-354, Sections 1501 (a)(5) and 1503 (c)(d)(e); Amended Section 402 (c); State Advisory Committee Policies (WCDC, MCC).*

Indicator 5.1

Evidence exists through signed clinical charts that SCREENING AND DIAGNOSTIC services are provided by Certified Nurse Practitioners, Certified Nurse Midwives, Physician Assistants, or Physicians.

(NOTE: Clinical breast exams, Pap and pelvic exams may be provided by nurses with documented special training related to that service who are supervised on site by a Certified Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, or Physician.)

This indicator may be met by:

Written policy/procedure/process is in place for nurses who are trained to perform clinical breast exams, pap exams and pelvic exams and are supervised on site by a Certified Nurse Practitioner, Physician Assistant, or Physician (if applicable).

Documentation Required:

- Evidence of signed screening and diagnostic provider contracts during current fiscal year.
- Written policy/procedure/process for nurses who are trained to perform clinical breast exams, pap exams, and pelvic exams and are supervised on site by a certified Nurse Practitioner, Physician Assistant, or Physician is in place (if applicable).

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Indicator 5.2

The local coordinating agency has and uses the most recent version of the BCCCP Medical Protocol on site.

This indicator may be met by:

The local health department produces a copy of the current BCCCP Medical Protocol upon request.

Documentation Required:

Copy of the most current BCCCP Medical Protocol.

Evaluation Question:

Has the local health department provided the specified documents required for the evaluation?

Indicator 5.3

The local coordinating agency has a policy/procedure in place that describes the process implemented to ensure all contracted providers have received and reviewed the current BCCCP medical protocol.

This indicator may be met by:

The local coordinating agency can produce a copy of a written policy/procedure describing the process for ensuring all contracted providers receive and review the current BCCCP medical protocol.

Documentation Required:

Copy of policy/procedure describing the process for distributing and reviewing the BCCCP Medical Protocol with contracted providers.

Evaluation Question:

Has the local health department provided the specified documents required for the evaluation?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

MPR 6

Obtain each woman's informed consent at the beginning of each annual screening cycle.

References: *State Advisory Committee Policy (WCDC).*

Indicator 6.1

Documentation exists that describes how the local coordinating agency maintains systems for orienting women to the BCCCP including:

Explaining the informed consent and the process for obtaining a woman's signature. The informed consent MUST include the following information:

1. Program eligibility for insured and/or uninsured women. Statement of health department's practice for verifying clients' self-reported insurance coverage and consequences for the client if insurance status is not accurately reported;
2. Description of breast and cervical cancer screening tests available;
3. Statement that not all screening and diagnostic services are reimbursed by the program and the woman may have to pay for services/procedures not covered by the program; **AND**
4. Assistance provided by the local coordinating agency in assisting women to obtain follow-up services at the time of initial screening and possibly cancer treatment if the woman is diagnosed through the program.

This indicator may be met by:

Review of agency's informed consent to assure items in # 1-4 above are included.

Documentation Required:

Informed consent containing required information as stated.

Evaluation Question:

Does the agency's informed consent contain information as stated in # 1-4 above?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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Indicator 6.2

The agency can provide a written policy/procedure describing the process for:

1. Determining a client's eligibility for the program.

2. Assuring completion of all appropriate program paperwork by the client especially for women who need assistance for any reason – such as a communication deficit.

3. Obtaining (and re-verifying) the client's informed consent on an annual basis.

4. Scheduling the appropriate screening services.

5. Describing the agency's availability to assist with seeking follow-up services at the time of initial screening and again, at the time that a woman is informed she has a cancer diagnosis.

This indicator may be met by:

Written policy/procedure describing the process for:

- Determining a client's eligibility for the program.
- Assuring completion of all appropriate program paperwork by the client.
- Obtaining (and re-verifying) the client's informed consent on an annual basis.
- Scheduling the appropriate screening services.
- Describing the agency's availability to assist with seeking follow-up services at the time of initial screening and again, at the time that a woman is informed of follow-up needed for an abnormality.
- The agency is able to show evidence of signed/initialed and dated informed consents of clients receiving services during a specified time period.

Documentation Required:

- Written process describing how BCCCP women are enrolled in the program, explained the informed consent, scheduled for screening services, and informed of the local health department's availability to assist with seeking follow up services for an abnormal screening result.

- Client charts will be reviewed for evidence of signed/initialed and dated informed consents covering the time period screening and diagnostic services were rendered (1 year from date signed on form).

Evaluation Questions:

- Has the agency provided a written process describing requirements as outlined under "This indicator may be met by"?

- The agency is able to show evidence of signed/initialed and dated informed consents of clients receiving services during a specified time period as identified by MDCH reviewers.

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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MPR 7

There is a system in place to monitor and to take corrective action as appropriate to assure that each enrolled woman is provided screening, diagnostic, and treatment services as needed, regardless of her ability to pay.

References: *PL 101-354, Sections 1501 (a)(1)(2) and 1503 (a)(1)(2)(a)(b); CDC Administrative Guidance; CDC Performance Indicators.*

Indicator 7.1

Evaluation of CDC Timeliness Performance Indicator (through Annual Chart Reviews).

Evidence is available from ANNUAL CHART REVIEWS that all women requiring IMMEDIATE follow-up based on abnormal breast and cervical screening results are receiving appropriate diagnostic services and/or treatment on a timely basis as defined in the CDC TIMELINESS Performance Indicators:

1. 75% of cases in which there is an abnormal screening result (requiring immediate follow-up) should have a final diagnosis within 60 days (for abnormal breast results) and 90 days (for abnormal cervical results) of the date of that screening result; **OR**

2. Charts of identified women requiring breast and/or cervical diagnostic and treatment services based on an abnormal breast/cervical screening results requiring immediate follow-up indicate that women: have demonstrated at least a 10% improvement towards achievement of the indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local coordinating agency's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

This indicator may be met by:

Charts of identified women requiring breast and/or cervical diagnostic and treatment services based on an abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received timely care according to the CDC Performance Indicators; **OR**

- Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None at site, part of annual medical chart review.

Evaluation Question:

None at site visit.

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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Indicator 7.2

Evaluation of CDC Completeness Performance Indicator (through Annual Chart Reviews).

Evidence is available from ANNUAL CHART REVIEWS that all women requiring IMMEDIATE follow-up based on abnormal breast and cervical screening results are receiving: Appropriate diagnostic follow-up services with a documented final diagnosis and treatment disposition as defined in the CDC COMPLETENESS Performance Indicators:

- 90% of abnormal screenings (requiring immediate follow-up) must have diagnostic work-up, final diagnosis, and treatment disposition documented.

This indicator may be met by:

Charts of identified women requiring breast and/or cervical diagnostic and treatment services based on an abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received appropriate and complete care according to the CDC Performance Indicators; **OR**
- Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None at site, part of annual medical chart review.

Evaluation Question:

None at site visit.

Indicator 7.3

The local coordinating agency provides evidence of providing assistance for BCCCP women diagnosed with breast or cervical cancer. For BCCCP women who **DO** qualify for the Medicaid Treatment Act, documentation exists of a woman's cancer diagnosis or precancerous condition and supporting documentation as required by Medicaid for coverage through the program.

This indicator may be met by:

The local coordinating agency is able to produce, upon request, ALL of the following information for an identified sample of BCCCP women who are eligible for the Medicaid Treatment Act:

1. Documentation indicating a woman's cancer diagnosis or precancerous condition;

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2. Verification of the woman's identify (photo ID);
3. Verification of the woman's citizenship status;
4. A copy of the signed Medicaid application; and
5. A copy of the Medicaid approval letter indicating the effective date of coverage.

Documentation Required:

For all women enrolled under the Medicaid Treatment Act, documentation as described under the first bullet point in "This indicator may be met by" is provided.

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

Indicator 7.4

The local coordinating agency provides evidence of providing assistance for BCCCP women diagnosed with breast or cervical cancer For BCCCP women who **DO NOT** qualify for the Medicaid Treatment Act, a policy/procedure is in place describing the local coordinating agency's role in assisting women to obtain needed cancer treatment services.

This indicator may be met by:

- The local coordinating agency is able to produce upon request a policy/procedure describing their role in assisting women NOT eligible for BCCCP MTA to obtain needed cancer treatment services. The policy/procedure describes how the agency will assist women with obtaining cancer treatment services.

Documentation Required:

For all women enrolled under the Medicaid Treatment Act, documentation as described under the first bullet point in "This indicator may be met by" is provided.

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

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Monitoring/Reimbursement of Clinical Services

MPR 8

Assure compliance with the "funds of last resort" requirement in the federal law.

Reference: *PL 101-354, Section 1504 (d)(1)(2).*

Indicator 8.1

Each client's insurance information is accurately recorded at the time of enrollment and at each rescreening visit. A front and back copy of each insured client's insurance card is made at the time of enrollment and at each rescreening visit or documentation stating reason why copy of insurance card could not be obtained. Whenever possible, coverage for BCCCP services is verified with the insurance carrier to ensure that the client's plan is not a prepaid managed care plan or other arrangement under which the client could receive coverage for BCCCP services by seeing a plan provider.

This indicator may be met by:

The local health department maintains on file:

- A front and back copy of each insured client's insurance card that is made at the time of enrollment and each rescreening visit or documentation stating reason why copy of insurance card could not be obtained; **AND**
- Written evidence of the local health department's process/procedure for determining BCCCP eligibility for insured women. This process/ procedure should include a statement of the health department's practice regarding verification of clients' self-reported insurance coverage.

Documentation Requested:

- Client chart records, and copy of front and back of the insurance cards (or record of why insurance card could not be obtained) for all insured clients documenting insurance information for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).
- Written policy outlining steps/procedures for determining BCCCP eligibility for insured women. Policy should also include a statement of the local health department's procedure for verifying self-reported insurance coverage, and should also include what steps are taken to assure that women insured through a prepaid managed care plan or comprehensive PPO are excluded from the program.

Evaluation Questions:

- Has the local health department provided written policy for evaluation with all specified documentation required?
- Do May chart records/ insurance records of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) show evidence that each client's insurance information is

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accurately recorded at the time of enrollment and at each rescreening visit (e.g., copy of insurance card, accurately documented on the client enrollment form, etc)?

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MPR 9

There is a system in place to monitor and take corrective action as appropriate, to assure that the reimbursement amount for each BCCCP-approved service is accepted as payment in full.

References: *PL 101-354, amended Section 402 (a)(1)(3); CDC Administrative Guidance.*

Indicator 9.1

Fully executed, current, written arrangements, consistent with BCCCP requirements, exist for all providers reimbursed by state or federal funds in the last fiscal year that has ended. This requirement is applicable to screening and/or diagnostic providers.

The local coordinating agency maintains, on file, a contract or letter of agreement with each BCCCP clinical service provider. The local coordinating agency provides documentation of a written policy or procedure stating that the provider:

- Agrees to accept up to the BCCCP reimbursement rate as payment in full (less insurance payment) for each BCCCP service; **AND**
- Has agreed, to the best of their ability, to not bill any BCCCP client for any service that is partially or fully covered by the BCCCP reimbursement amount for that service or similar language; **AND**
- That outlines corrective measures that will be implemented when inappropriate billing occurs. Inappropriate billing is defined as the following:
    - Billing for non-BCCCP approved services
    - Balance billing the client for charges above the BCCCP approved reimbursement rate

This indicator may be met by:

The local health department:

- Maintains on file a contract or letter of agreement with each BCCCP clinical service provider stating that the provider:
    - Agrees to accept up to the BCCCP reimbursement rate as payment in full (less insurance payment) for each BCCCP service; **AND**
    - Will not bill any BCCCP client for any service that is partially or fully covered by the BCCCP reimbursement amount for that service or similar language.
    - Provides documentation of a written policy or procedure that states:
    - That providers have agreed, to the best of their ability, not to bill clients for any services that have been reimbursed by the BCCCP in part or in full; **AND**
    - That outlines corrective measures that will be implemented when inappropriate billing occurs.

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

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Documentation Requested:

- All signed last fiscal year ended BCCCP clinical service provider contracts or letters of agreement should be pulled from the files and made available to reviewers. Onsite reviewers will request a sample of signed BCCCP clinical service provider contracts or letters of agreement from the previous fiscal year.

- Written policy and/or procedure outlining procedure for identifying cases of inappropriate billing and corrective measures instituted to rectify inappropriate billing.

Evaluation Question:

- Does each subcontracted physician/hospital/laboratory arrangement, in the sample selected by the onsite reviewers, reflect the providers' agreement to accept the BCCCP reimbursement rate as payment in full for each BCCCP authorized procedure?

- Is there a policy outlining procedure for identifying cases of inappropriate billing and corrective measures instituted to rectify inappropriate billing.

Indicator 9.2

Assure that subcontractors are provided a copy of the BCCCP Unit Cost Reimbursement Rate Schedule which indicates the maximum rates for BCCCP screening and diagnostic services. Subcontractors may bill the MDCH Cancer Prevention and Control Section billing service up to the usual and customary charge; however, the reimbursement amount, including insurance payments, will not exceed the BCCCP approved rates.

This indicator may be met by:

The local coordinating agency maintains on file:

Agreements or communication methods documenting that subcontractors are provided a copy of the BCCCP Unit Cost Reimbursement Rate Schedule which indicates the maximum rates for BCCCP screening and diagnostic services.

Documentation Required:

- All signed last fiscal year ended BCCCP clinical service provider contracts or letters of agreement should be pulled from files and made available to reviewers. Onsite reviewers will select a sample for review.

- Copies of any communications with providers documenting all updates of BCCCP Unit Cost Reimbursement Rate Schedules during the last fiscal year ended.

Evaluation Question:

Has the local coordinating agency provided documentation of all updates to BCCCP Unit Cost Reimbursement Rate Schedules during the last fiscal year ended?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Indicator 9.3

(FOR HEALTH DEPARTMENTS PROVIDING CLINICAL SERVICES) – There is maximum recovery of all available insurance revenues for local coordinating agency-provided services through effective third party billing mechanisms, as evidenced by claims data/forms, Explanation of Benefits (EOB), or other auditor-approved documentation.

The local coordinating agency maintains on file billing records documenting that all available insurances have been billed appropriately and that each claim has been settled, as evidenced by EOBs or other auditor-approved documentation.

Financial documentation exists for all clinical services provided to each BCCCP client—by date of service—for local health department -provided BCCCP services. Records indicate the following information:

1. The amount billed to and paid by insurance (for insured clients as evidenced by an EOB or other auditor-approved documentation); and

2. The amount billed to the billing service contracted by MDCH to provide BCCCP reimbursement.

This indicator may be met by:

The local health department maintains on file financial records that show:

- The amount billed to the insurance company; **AND**
- The amount paid by the insurance company (if any), as evidenced by an EOB or other auditor-approved documentation; **AND**
- The amount billed to billing service.

Documentation Requested:

Financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) as indicated in "This indicator may be met by".

Evaluation Questions:

- Have financial records related to all services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served) been provided for evaluation, including at least one example of each item included in "This indicator may be met by" above?
- Do the financial records indicate:
  - The amount billed to the insurance company (if applicable)?
  - The amount paid by the insurance company (if any), as evidenced by an EOB or other auditor-approved documentation?
  - The amount billed to the billing service?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

MPR 10

Maintain, and utilize a computerized system (i.e., Michigan Breast and Cervical Cancer Control Information System-{MBCIS}) for tracking and monitoring clients.

References: *PL 101-354, Section 1501 (a)(6); CDC Administrative Guidance; CDC Performance Indicators.*

Indicator 10.1

Implementation of Client Tracking System

A tracking system is used to monitor and guide the care-coordination (and case management) provided to every enrolled woman. **AND**

Written process/procedure is in place that describes all of the following:

1. Plan for utilizing the monthly Case Management Report to identify and track women with abnormalities requiring immediate follow-up are receiving timely and complete care as described by the CDC Clinical Performance Indicators and BCCCP Medical Protocol;

2. Plan for tracking and notifying program women requiring short-term follow-up; and

3. Plan for identifying and notifying current women with normal test results when next annual screening visit is scheduled.

This indicator may be met by:

- Data from patient charts and the MBCIS are used to monitor and guide the care-coordination provided to every enrolled woman appropriately; **AND**

- Written process/procedure is in place that describes information contained in # 1, 2, and 3 above.

Documentation Requested:

Documentation of written process/procedure at time of site visit.

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

Indicator 10.2

Review of CDC Timeliness Performance Indicator Data in BCCCP database

Evidence is available through analysis of MBCIS DATA that demonstrates timeliness of clinical services as defined by the CDC TIMELINES Indicators:

1. 75% of cases in which there is an abnormal screening result (requiring immediate follow-up) should have a final diagnosis within 60 days of that result (for abnormal breast results) and 90 days of that result for abnormal cervical results; **AND**

2. 80% of clients with cancer diagnoses begin treatment within 60 days of the final diagnosis.

This indicator may be met by:

Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received appropriate care according to the CDC Performance Indicators; **OR**

- Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None. MDCH/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

None at site visit.

Indicator 10.3

Review of CDC Completeness Performance Indicator Data in BCCCP database

Evidence is available through analysis of MBCIS DATA that demonstrates COMPLETENESS of clinical service information as defined by CDC:

1. 90% of abnormal screenings (requiring immediate follow-up) must have diagnostic work-up, final diagnosis, and treatment disposition documented; **AND**

2. 100% of clients with a cancer diagnosis need to have a treatment disposition recorded in MBCIS within 100 days of diagnosis. (if applicable)

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section IX: Breast and Cervical Cancer Control Program (BCCCP)

This indicator may be met by:

Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received timely care according to the CDC Performance Indicators; **OR**
- Have demonstrated at least a 10% improvement towards achievement of the indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None. MDCH/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

None at site visit.

Indicator 10.4

All individuals that access MBCIS have a completed, signed User Information/Usage Agreement form on file at MDCH/Cancer Prevention and Control Section.

This indicator may be met by:

The local health department must provide a list of MBCIS users. The list of users must match the the MBCIS User and Web Access Form on file at MDCH/Cancer Prevention and Control Section.

Documentation Required:

A list of all MBCIS users with specific notation of those with "clinical" access and Discoverer access.

Evaluation Question:

Do all individuals with "clinical" and Discoverer access have a MBCIS User and Web Access form on file at MDCH?

For technical assistance, please contact Tory Doney at 517-335-8854 (doneyt@michigan.gov) or E.J. Siegl at 517-335-8814 (siegle@michigan.gov).

Section X: Family Planning

MPR 1

Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(1)*

Indicator 1.1

Broad Range of contraceptive methods. (3.4A; 7.0; 8.4; 7.1, 8.1.A.1.a & B.; 7.2B, D)

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 A.; 7.0 (all methods)
- 8.2.A (method counseling)
- 8.4 (broad range permanent & temporary methods)
- 8.5 (Infertility services)
- 8.7 (adolescent services)
- 7.1 (clinical protocols at each clinical site)
- 7.2 B, D. (client education on methods & informed consent)
- 8.1 A.1.a.
- 8.1 B.
- 5.2; 6.3.1H

To fully meet this indicator:

- The agency must provide a broad range of effective medically approved family planning methods and services including natural family planning methods, and temporary and permanent contraception either on site or by referral. (**3.4 A; 8.4; 7.0)**

- Written protocols and operating procedures must be in place and available at each clinical site **(7.0, 8.4 A)**

- Methods provided and for which written protocols must be in place include: **(8.4 B,C,D)**

    - Reversible Contraception
        - Hormonal contraceptives
            - at least 2 delivery methods combined hormonal contraceptives on site
            - at least 1 method progestin-only hormonal contraceptive on site
            - at least a second progestin-only method available on site within 2 weeks
        - Condoms (at least male condoms)
        - Intrauterine Device (IUD/IUS) either on site or by paid referral
        - Education materials and information regarding all methods including:
            - Hormonal contraceptives
            - Abstinence
            - Natural family planning (Fertility awareness)

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

        - Barrier methods
        - Intrauterine devices
        - Sterilization
        - Emergency contraception
    - Emergency Contraception
        - Emergency Contraception education and referral must be provided to all female clients
        - Written protocol must be in place
    - Permanent Contraception (Sterilization)
        - Education and information regarding sterilization must be provided for both male and female clients.
        - The agency must have a list of community providers where clients can be referred for sterilization. (Paid referrals for sterilization are not required)
        - Where provided, the consent process for sterilization must assure the client's decision to undergo sterilization is voluntary and made with full knowledge of the permanence, risks, and benefits associated with both male and female sterilization
        - All federal regulations on sterilization must be met if the procedure is performed by the delegate:
            - The client must be at least 21 years of age and mentally competent
            - The client must voluntarily given his or her informed consent using the required consent form (Consent for Sterilization form HHS-687 (11/06), OMB no.0937-0166 (expiration date 11/09)
        - For sterilization providers, informed consent must have been signed at least 30 days, but not more than 180 days before the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery

- Specific education for the contraceptive methods and the method-specific consent forms must be part of the agency's service plan. The education must provide information to make an informed decision on the specific methods, including their use, safety, effectiveness, benefits, risks, complications, adverse effects, discontinuation issues, danger signs and effectiveness in preventing STIs. **(8.1A; 8.1B2)**

- The initial visit must include education related to all methods and must be documented in the medical record. **(7.2 B. 1)**

- Individual counseling to assist the client in making an informed choice must be done prior to the client making an informed choice regarding a particular birth control method. **(7.2 C.1)**

- Counselor must have knowledge to provide accurate information about the benefits, risks, safety, effectiveness, side effects, complications, discontinuation issues, danger signs of contraceptive methods, and effectiveness of preventing sexually transmitted infections. **(8.2)**

- A contraceptive method specific consent form must be completed before each prescriptive method is given. **(8.1 B.2)**
    - Informed consent must follow method specific education.
    - Information and informed consent must be specific to the contraceptive method.
    - There must be a separate consent for each prescriptive method.

- All consent forms must **(8.1 B. 2c,d & 4b)**:
    - Be part of the client's record
    - Be updated if there is a change in the client's health status or a different prescriptive method is chosen

Section X: Family Planning

- Medical records of transfer clients receiving prescriptive methods must contain: **(10.2 B.1,2)**
  - Documentation of a full exam within past 12 months
  - Completed client history
  - Completed informed consent
  - Clinician documentation of the prescription

- Exit counseling for clients receiving prescriptive methods must include instructions on how to use the method, danger signs, how to obtain emergency care after hours, a suggested return schedule, and any needed referrals and follow-up. **(7.2 H & I)**

Documentation Required:

- Protocol and operating procedures manual specific to all contraceptive methods services
- Method specific consents for each prescriptive contraceptive method
- Educational materials for all methods
- Access to clients' records
- Consent forms used for sterilization

Evaluation Questions:

- Are the required methods of contraception available, on site or by referral, with written protocols in place?
- Are the written protocols and operating procedures covering all services and available contraceptives up to date and available at each clinic site?
- Are all contraceptive educational materials current and available?
- Does the initial visit include education related to all methods? Is it documented in the medical record?
- Are counselors knowledgeable to accurately provide the required information regarding contraceptive methods?
- Are all requirements for method specific consent forms met?
  - Completed before the method is given?
  - Education provided before the consent form is given?
  - A method specific consent for each prescriptive method?
  - Education is specific to each contraceptive method?
  - The method specific consent is as part of the client record?
  - Consent is updated when there is a change in the prescriptive method?

- Do medical records of transfer clients receiving prescriptive methods must contain documentation of a full exam within the past 12 months; a complete client history; completed informed consent; and clinician documentation of the prescription? **(10.2 B.1,2)**

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Indicator 1.2

Level I Infertility Services.
See Michigan Title X Family Planning Standards & Guidelines 2011

- 8.5 Level I (infertility)
- 3.4 A

To fully meet this indicator:

- The agency must have Level I infertility services with written infertility service protocols and operating procedures, including **(8.5)**:
    - Initial infertility interview/assessment
    - Education and counseling including human reproduction and sexuality, risk and benefits to any proposed diagnostic and therapeutic measures
    - Physical examination
    - Appropriate referral
- The agency infertility service protocol must make basic infertility (level I) services available to women and men desiring such services: **(8.5)**

Documentation Required:

- Protocol and Operating procedure manual
- Infertility educational materials
- Referral services provider listing

Evaluation Questions:

- Are required elements of Level I infertility services offered?
- Does the agency have a protocol for at least Level I infertility services?
- Are current education and referral materials available?

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Section X: Family Planning

Indicator 1.3

Services for Adolescents. (8.7 A & B; 6.2.A.6; 6.3.1 H)

To fully meet this indicator:

- Annual service plan must address delivering services to adolescents and the number of adolescents projected to be served **(8.7. A; 6.2 A. 6.)**
- Must not require written consent of parents or guardians for the provision of services to minors nor notify parents or guardians before or after a minor has requested and received family planning services **(8.7. A)**
- Adolescents seeking contraceptive services must be informed of all methods of contraception **(8.7. A.1)**
- Written protocols and operating procedures must be in place that addresses adolescent counseling including **(8.7. B.1)**:
    - Assurance of confidentiality of services
    - Creating an atmosphere in which adolescents are comfortable
    - Informing adolescents of all methods of contraception, including abstinence
    - Discussing of STI's and HIV and encouraging adolescents to participate in exam and testing as indicated
    - Encouraging participation in the agency's medical services, including physical exam, laboratory testing, and treatment as indicated
    - Encouraging family participation in the decision of minors to seek family planning services
    - Counseling on how to resist attempts to be coerced into sexual activities
    - Informing adolescents that in special cases (e.g. child abuse) reporting is required
- Adolescent counseling must be documented in the client record **(8.2; 8.2 C)**
- Confidentiality cannot be invoked to circumvent reporting requirements for child abuse and neglect. **(5.2)**
- The agency must charge a minor obtaining confidential services based on the resources of the minor and not on the family income. **(6.3.1H)**

Documentation Required:

- Protocols and operating procedures that address adolescent services and adolescent counseling
- Access to adolescent records to review documentation
- Educational materials that address contraceptives and adolescent services
- Annual Plan addressing adolescent services and caseload

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Does the agency's annual service plan address services to adolescents and the number of adolescents projected to be served?
- Do policy and operating procedures call for providing services to adolescents without requiring written consent of parents or guardians?
- Do written protocols and operating procedures for adolescent counseling include all requirements?
- Are required adolescent counseling issues documented in the client record?
- Do policies and operating procedures assure that confidentiality is not invoked to circumvent reporting requirements for child abuse and neglect?
- Do agency policy and operating procedures stipulate that minors seeking confidential services are charged based on the resources of the minor, not on the family income?

Section X: Family Planning

MPR 2

Provide services without subjecting individuals to any coercion to accept services or to employ or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participate in any other program.

References: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(2)*

Indicator 2.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 B. 1, 2, 3
- 5.1

To fully meet this indicator:

- Delegate agencies providing family planning services must assure services will be provided to clients:
  - On a voluntary basis
  - Without coercion to accept services or any particular method of family planning
  - Without making acceptance of services a prerequisite to eligibility for any other service or assistance in other programs **(3.4 B.1,2,3; 5.1)**

- Staff must be informed they may be subject to prosecution under federal law if they coerce or endeavor to coerce any person to accept abortion or sterilization **(5.1)**

Documentation Required:

- Policy and operating procedures that address voluntary participation without coercion, eligibility or prerequisite
- Agency general consent for services form
- Documentation that staff has been informed of the possibility of prosecution if they coerce any client to accept abortion, sterilization, or any specific method of contraception

Evaluation Questions:

- Is there a policy statement that services are voluntary, provided without coercion, eligibility requirements or any prerequisite?
- How is the fact that services are voluntary and provided without coercion or prerequisite communicated to clients in the clinic? (verbally, written, included in consent forms, in signage?)
- Do clients express any feelings of coercion during interview?

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Is there documentation that all staff has been informed of the possibility of prosecution if they coerce any client to accept abortion, sterilization, or any specific method of contraception?

Section X: Family Planning

MPR 3

Provide services in a manner which protects the dignity of the individual.

References: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(3)*

Indicator 3.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 C; 5.0 B (dignity & respect)
- 5.2
- 5.5 A 1 a – b
- 5.5 B
- 7.0 B, C
- 7.2 A
- 10.3 C

To fully meet this indicator:

The agency must:

- Provide services in a manner that will protect each individual's dignity and respects the diverse cultural and social practices of the service area population **(3.4 C)**

- Have written policy and/or operating procedures to assure the dignity and respect for cultural and social practices of the individual **(5.0 B)**

- Service delivery to all clients must include the following **(7.2 A)**:

    - Assuring clients are treated courteously and with dignity and respect
    - The opportunity to participate in planning their own medical treatment
    - Encouraging clients to voice any questions or concerns they may have

- Client confidentiality must be assured **(7.0 C; 7.2 A.2; 10.3 C)**

    - A confidentiality assurance statement must appear in the client's record
    - Assurance of confidentiality must be in Policy and Procedures
    - Delegate agency personnel must assure confidentiality, such as a confidentiality statement

- The clinic must have safeguards to provide for the confidentiality and privacy of the client as required by the Privacy Act **(5.2; 7.0 B)**

- A system must be in place to keep client records confidential **(10.3 C.)**

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Not disclose client information without the client's consent, except as required by law or as necessary to provide services **(5.2; 10.3 C.3)**
- Information collected for reporting purposes is disclosed only in summary or statistical form **(5.2;10.3 C.4)**
- Upon request, transferring clients must be provided with a copy or summary of their record to expedite care. **(10.3 C. 5)**
- Upon request, clients must be given access to their medical record **(10.3 C.6)**
- Delegate agency must obtain MDCH approval to conduct any clinical or sociological research using Title X clients as subjects **(5.5 A & B)**

Documentation Required:

- Policy and Procedure Manuals
- Client rights sheet/poster
- Client records

Evaluation Questions:

- Do policies and procedures address treating clients with dignity and respect for diverse cultural and social practices, and assure client confidentiality?
- When services are provided, are clients treated courteously and with dignity and respect?
- Are clients encouraged to ask questions and to participate in their plan of medical care?
- Does a client confidentiality statement appear:
  - In the client's record
  - Stated in Policy and Procedure
- Do all delegate agency personnel assure confidentiality, as in a signed statement?
- Is information released only with the client's written consent, unless disclosure is required by law?
- Is there a system in place to maintain confidentiality of client records?
- Upon request, are clients provided access or given a copy of their medical record?
- Is information collected for reporting purposes disclosed only in summary or statistical form?
- If the agency conducted any research, was MDCH's approval received before it began?
- Do procedures and clinic flow provide for the confidentiality and privacy of the client?

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

MPR 4

Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(4)*

Indicator 4.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 D; 5.0 B (non discrimination)
- 5.6 (LEP services)
- 6.4 (Accessibility of Services and Facilities)
- 7.2 A.5; 8.1B.4.a. (Accessibility of Materials)
- 6.7 (FPAR reporting requirements)

To fully meet this indicator:

- The local agency *must* have written policies and procedures of non-discrimination in providing services **(5.0 B)**
- The agency must comply with [45 CFR Part 84], which requires among other things that the recipients of Federal funds operate their programs so that, when viewed in their entirety, they are readily accessible to people with disabilities **(6.4)**
- The local agency must have a written plan including all required components to ensure meaningful access to services for persons with limited English proficiency **(5.6)**
- All consent forms must be written in the primary language of the client or translated and witnessed by an interpreter **(8.1 B.4.a)**
- The agency must comply with the Office of Population Affairs FPAR, including accurate collection of race and ethnicity data (FPAR Tables 2 and 3) **(6.7)**

Documentation Required:

- Non-discrimination policy
- Copy/location of agency's posted or distributed non-discrimination policy
- Limited English Proficiency (LEP) plan
- Consent forms written in languages other than English, as appropriate
- Client demographic data form

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Does the agency have a policy compliant with non-discrimination based on:
    - Race?
    - Religion?
    - Color?
    - National origin?
    - Creed?
    - Handicapping condition?
    - Sex?
    - Age?
    - Number of pregnancies?
    - Contraceptive preference?
    - Marital status?

- Is the non-discrimination policy communicated to all clients (written or verbally)?

- Is the non-discrimination policy posted in the clinic?

- Are facilities accessible to individuals with disabilities including but not limited to:
    - Entrance ramps are clearly marked and easily accessible?
    - Toilets accessible to the handicapped?
    - Handicapped parking?

- Does the agency/facility provide meaningful access for persons with limited English proficiency?

- Does the LEP plan:
    - Identify LEP individuals who need language assistance?
    - List what language assistance measure will be taken (oral interpretation or written translation)?
    - Describe how staff will be trained?
    - Provide notices to LEP persons?
    - Monitor and updated the LEP plan appropriately?
    - Include statements of the agency's commitment to meaningful access?
    - State that services will not be denied because of limited English proficiency?
    - State that LEP services will be provided at no cost to the client?
    - State that clients will not be asked or required to provide their own interpreter? If the client chooses to use family or friends, has the client been informed of the right to receive free LEP services and has declining these services been documented?
    - Appropriately address the scope and complexity of delivery service for the size and frequency in the target population served?

- Has the agency's LEP plan been submitted for review by MDCH?

- Are all consent forms either written in the primary language of the client or translated and witnessed by an interpreter?

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Does the agency accurately collect race and ethnicity data on its client data system to assure accurate data for the FPAR?

Section X: Family Planning

MPR 5

Not provide abortion as a method of family planning. Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options: (A) Prenatal care and delivery; (B) Infant care, foster care, or adoption; and (C) Pregnancy termination.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(5) and (i)*

Indicator 5.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 E (Not provide Abortion)
- 8.6 A, B, D, E (Pregnancy Diagnosis and Counseling)

To fully meet this indicator:

The agency must:

- Not provide abortion services as a method of family planning **(3.4 E)**
- Provide pregnancy diagnosis and counseling to all clients in need of this service, including education and counseling about family planning services as indicated. **(8.6)**
- Have written protocols and procedures to offer pregnancy diagnosis services that include: **(8.6)**
  - Informed consent for pregnancy testing
  - Pertinent history
  - Highly sensitive pregnancy test
  - Offer physical exam, or provide counseling regarding importance of physical assessment
  - Offer non-directive pregnancy counseling services
  - If ectopic pregnancy is suspected, immediate referral for diagnosis and treatment must occur. Follow-up must be documented in the medical record
- Pregnancy options counseling services must be provided in a non-directive, unbiased manner. If requested to provide such information and counseling, factual information and referral upon request are provided. **(8.6 B)**
- Personnel involved in pregnancy diagnosis and counseling must have knowledge of: **(8.6 E**)
  - Pregnancy testing procedures
  - Prenatal care and delivery
  - Infant care, foster care and adoption
  - Pregnancy termination
  - Local availability of referral services
  - Methods of contraception
  - Federal and state requirements regarding mandatory reporting, options counseling, and abortion laws
  - Non-directive counseling skills and techniques

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Documentation Required:

- Protocol and operating procedures for pregnancy diagnosis and counseling
- Client medical records
- Pregnancy test consent form
- Educational materials related to pregnancy
- Referral listing of providers
- Laboratory manual for pregnancy testing controls
- Laboratory log of pregnancy tests performed

Evaluation Questions:

Does the agency's policy and procedure manual include:

- That abortion services are not provided as a method of family planning?
- That pregnancy diagnosis and counseling is provided to all clients in need of this service?
- That pregnancy diagnosis service consists of:
  - Informed consent
  - History, including signs and symptoms of ectopic pregnancy and past history of STI and PID
  - Physical exam offered
  - Pregnancy test
  - If ectopic pregnancy is suspected, is the client referred for immediate diagnosis and treatment? Is follow-up documented in the medical record?
- Are those with positive pregnancies offered counseling services and referral upon request?
- Does pregnancy counseling service include:
  - Information and counseling provided in a factual, non-directive, unbiased manner?
  - Information about prenatal care and delivery; Infant care, foster care, adoption and pregnancy termination unless the client indicates she does not wish to receive such information?
- Is the referral list current and does it include a full range of providers for pregnancy care?
- Does a laboratory log exist of tests performed?
- Are pregnancy counseling personnel knowledgeable to provide counseling and referral information in a non-directive manner?

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

MPR 6

Provide that priority in the provision of services will be given to persons from low-income families.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(6)*

Indicator 6.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 F
- 6.3 I

To fully meet this indicator:

The agency must:

- Have written policies and/or procedures to assure that no patient is denied services or is subject to any variation in quality of services because of inability to pay **(6.3.1)**
- Strive to increase use of services by historically under-served segments of the population **(3.4 F)**
- Have policy and/or procedures to ensure that low-income clients are given priority to receive services **(3.4 F)**

Documentation Required:

- Sliding fee scale
- Non-discrimination policy for ability to pay
- Policy and/or Procedures to assure that low-income clients are prioritized
- Agency or MDCH Family Planning brochure describing eligibility and services

Evaluation Questions:

- Are low-income individuals prioritized for family planning services? (Such as in scheduling practices, promotion of the program to low income populations and historically underserved populations, location of services)
- Are low-income clients informed that services are provided regardless of ability to pay?

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Section X: Family Planning

MPR 7

Provide that no charge will be made for services provided to any persons from a low-income family (at or below 100% of the Federal Poverty Level) except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(7)*

Indicator 7.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 G
- 6.3.1 C,D,K
- 6.7

To fully meet this indicator:

The local agency must have written policies and procedures for billing and collecting client fees; these policies must include the following:

- Clients whose documented income is at or below 100% of the federal poverty level must not be charged; although projects must bill third parties authorized or legally obligated to pay for services. **(3.4 G; 6.3.1 C)**
- Individual eligibility for a discount must be documented on the client's record/file. **(6.3.1 D)**
- Voluntary donations from clients are permissible; however, clients must not be pressured to make donations. **(6.3.1 K)**
- The agency must comply with the Office of Population Affairs FPAR, including accurate collection of client income. **(6.7)**

Documentation Required:

- Client records showing eligibility for discount for services/billing sheets
- Proportional sliding fee schedule established using current DHHS Poverty Guidelines
- Written agency policy and procedures for charging, billing and collecting client fees
- Client demographic data form

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Do the billing and client fee collection procedures include that agency fees are discounted 100% for clients whose income is at or below 100% of poverty?
- Is family income determination consistent with agency policy and or procedure manual?
- Are donations accepted in a manner that does not pressure the client?
- Do the clients' records show income and family size?
- Does the agency accurately collect income data on its client data system to assure accurate data for the FPAR?

Section X: Family Planning

MPR 8

Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to person from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(8)*

Indicator 8.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 H. 1 - 3
- 6.3.1 A, B, G, J

To fully meet this indicator:

- The local agency must have written policies and procedures for billing and collecting client fees. **(6.3.1)**
- The agency must develop a schedule of discounts for individuals with family incomes between 101% and 250% of the federal poverty level that is proportional and based on current Federal poverty levels. **(6.3.1 B)**
- At the time of services, clients who are responsible for paying any fee for their services must be given a bill directly. **(6.3.1.A)**
- Bills to clients must show total charges less any allowable discounts. **(6.3.1.G)**
- Fees must be waived for individuals with family incomes above the federal poverty level who, as determined by the site manager, are unable, for good cause, to pay for family planning services. **(6.3.1B)**
- A method of "aging" of outstanding accounts must be established. **(6.3.1 J)**

Documentation Required:

- Client records showing eligibility determination for services
- Client Bills/Receipts
- Billing records
- Sliding fee schedule using current DHHS Poverty Guidelines

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Written agency policy for charging, billing and collecting client fees
- Agency procedure for aging outstanding accounts
- Financial Status Reports

Evaluation Questions:

- Does the agency have a schedule of discounts that is evenly distributed for individuals with family incomes between 101% and 250% of the federal poverty guidelines?
- Is the agency fee schedule based on the current DHHS poverty guidelines?
- Does the agency offer bills showing total charges less any allowable discounts to clients responsible to pay?
- Are fees waived for individuals with family incomes above the federal poverty level who, as determined by the site director, are unable to pay for services?
- Are reasonable efforts to collect charges without jeopardizing client confidentiality made?
- Does the agency have an established method of aging outstanding accounts?
- Does the clients' record document eligibility for a discount, based on the sliding fee scale?
- Do Financial Status Reports show revenues from client collections?

Section X: Family Planning

MPR 9

If a third party (including a government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title agency is required.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(9)*

Indicator 9.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 J.
- 6.3.1. A, C, E, F, I

To fully meet this indicator:

- Charges must be based on a cost analysis of all services provided by the project…In cases where a third party is responsible; bills must be submitted to that party. **(6.3.1 A,C)**
- The agency must use reasonable effort to collect charges without jeopardizing client confidentiality. **(6.3.1 I)**
- The agency must bill third party payer's total charges without applying any discount. **(6.3.1.E)**
- The agency must have written agreements with Title XIX, XX, or XXI agencies, or have bills and receipts of reimbursement from these agencies, where applicable. **(6.3.1 F)**

Documentation Required:

- Written agreements with the title agencies for cost reimbursements for services provided to eligible clients, if applicable
- Client records showing third party eligibility for services
- Written policy and/or procedures for charging, billing and collecting client fees from third party payers
- Billing for Title XIX, XX or XXI and receipts of reimbursements
- Financial Status Reports

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Does the agency have a written policy for charging, billing and collecting fees from third party payers for services that are in compliance with the federal and state guidelines?
  - Does the agency bill third party payers the total charges without applying any discount?
  - Billing does not breach confidentiality?

- Are there written agreements with Title XIX, XX, or XXI agencies for reimbursement or has the agency received reimbursements?

- Is there evidence the agency follows their billing and client fee collection procedures?

- Are third party reimbursements reflected on the Financial Status Report?

Section X: Family Planning

MPR 10

Provide for an advisory committee.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(11).*

Indicator 10.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4. K., U.
- 4.0 C. 1 - 4
- 6.9. A

To fully meet this indicator:

The agency must have a governing board or program specific Family Planning Advisory Council:

- The council/board must be representative of the population served and include persons knowledgeable about family planning. **(4.0 C.1)**
- The council/board must have more than 5 members but no more than 9 members, unless size of body has been waived by MDCH. **(4.0 C.2)**
- Minutes of all meetings must be kept and must demonstrate the following activities **(4.0 C.3,4)**:
    - Monitoring of program/policy issues and makes recommendations to the agency on the organization, management, and operation of the Family Planning program. This includes review and input into the agency annual plan including goals and objectives
    - Review the agency's progress toward meeting the needs of the priority population and for making clinic services and policies more responsive to their needs and preferences
    - Evidence of meeting at least twice a year

Documentation Required:

- Governing Board or Family Planning Advisory Council Roster
- Governing Board or Family Planning Advisory Council meeting schedule
- Governing Board or Family Planning Advisory Council meeting minutes

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Section X: Family Planning

Evaluation Questions:

- Does the agency have an advisory body of at least five members up to nine members?
- Are there members representative of the population served (teen and adult consumers)?
- Are there members knowledgeable about family planning?
- Is there evidence the advisory body has input into the planning, implementation and evaluation of family planning services?
- Is there evidence that the advisory body has reviewed the annual plan and program goals and objectives?
- Does the group meet at least twice a year?
- Are there minutes of all meetings?

Indicator 10.2

Information and Education (I&E) Committee

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 K., U.
- 4.0 D.
- 6.8
- 6.10

To fully meet this indicator:

- The agency must have an Information and Education (I & E) committee to review and approve all informational and educational materials developed or made available by the project. (The Family Planning Advisory Committee may take on this role.) **(4.0 D., 6.8)**
- The I & E committee must be five to nine members unless size of body has been waived by MDCH. **(6.8)**
- The I & E committee membership must be broadly representative of the community served. **(6.8)**
- The I & E committee must **(6.8)**:
    - Consider the educational and cultural backgrounds of the individuals to who the materials are addressed
    - Consider the standards of the population to be served with respect to such materials
    - Review the content to assure the information is factually correct
    - Determine whether the material is suitable for the population
    - Establish a written record of its determinations
    - Approve all publications prior to disbursement

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Section X: Family Planning

- Federal grant support is acknowledged in any publication produced with family planning grant funds. **(6.10)**

Documentation Required:

- Information and Education Committee Roster
- Information and Education Committee Meeting Minutes
- Written Record of Information and Education Committee determinations related to materials
- Publications acknowledge federal grant support

Evaluation Questions:

- Did the I & E review and approve all informational and educational materials used in the Title X program?
- Does the I & E committee have five to nine members unless a waiver was approved by MDCH?
- Is the I & E committee membership broadly representative of the community (teen and adult consumer)?
- Did the I & E committee consider the educational and cultural backgrounds of the individuals to whom the materials are addressed?
- Did the I & E committee consider the standards of the population to be served with respect to such materials?
- Did the I & E committee review the content of all informational and educational materials to assure the information is factually correct?
- Did the I & E committee determine whether the material is suitable for the population?
- Is there a written record of the determinations of the I & E committee?
- Is there documentation that all publications approved by the I & E prior to disbursement?
- Do publications produced with any family planning grant funds acknowledge federal grant support?

Section X: Family Planning

MPR 11

Provide for medical services related to family planning (including physician's consultation, examination prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(1)*

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 L Medical Services Related to Family Planning
- 6.5.C.10 OSHA compliance
- 7.0 Required Client Services
- 7.1 Service Plan and Protocols
- 7.2 Service Procedural Outline
- 7.3; 6.4 Emergency Situations
- 7.4 Referrals and Follow-up
- 8.1.A. Client Education
- 8.3 History, Physical, and Laboratory Testing
- 8.8 DES Exposure Identification
- 9.2 STI and HIV Services
- 10.1 Equipment & Supplies
- 10.2 Pharmaceuticals
- 10.3 Medical Records
- 10.4 A, B Quality Assurance System

Indicator 11.1

Provision of required clinical services under approved clinical protocols and guidelines (3.4 L; 7.0; 7.0 A; 7.0.A.1; 7.1; 7.4; 8.1.B)

To fully meet this indicator:

The agency must:

- Provide medical services related to family planning required in the law, regulations, or guidelines for the provision of high quality family planning services to clients who want such services. **(3.4 L; 7.0)**

- Have an MDCH approved waiver for any requirement or required service not provided. **(7.1)**

- Use approved protocols for the provision of all family planning services **(7.0 A 1; 7.1)**
  - Protocol manual must be available at each clinic site. **(7.1)**
  - MDCH Title X Family Planning Standards and Guidelines Manual must be at each site. **(7.1)**
  - Clinical protocols must be consistent with MDCH Title X Standards and Guidelines, Michigan Law, and nationally recognized standards of care. **(7.1)**

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Section X: Family Planning

- Obtain a signed general consent covering exam and treatment prior to the client receiving services **(7.2D)**
- Provide an explanation of all procedures and range of available services to clients **(7.2 A 6)**
- Have a written client education plan. (8.1.A)
- Have in place protocols that address the following: **(8.3 B)**
  - Provide that physical exam and laboratory test requirements for specific methods of contraception are followed **(8.3 B.1)**
  - If a physical exam and related preventive services is deferred beyond 6 months there must be a compelling reason documented by the clinician in the client record. **(8.3 B.2,3)**
- Written protocols and operating procedures for referrals and follow-up must be in place for: **(7.4)**
  - Referrals that are made as result of abnormal physical exam or laboratory findings
  - Referrals for required services not provided on-site
  - Referrals for services determined to be necessary but beyond the scope of family planning
- Revisit schedules must be individualized based on the client's need for education, counseling and clinical care beyond that provided at the initial and annual visit. **(8.3 G)**

Documentation Required:

- Service protocol and procedure manuals
- Health care service plan
- Access to client medical records

Evaluation Questions:

- Do all services have written protocols and procedures including:
  - History and physical examination requirements?
  - Contraceptive services?
  - Laboratory services?
  - Medical emergencies?
  - Medical records?
  - Pharmaceuticals?
  - Any other services provided by the program?
  - Sexually transmitted infections, including HIV?
- Are current written clinical protocols reviewed and signed annually by the agency's medical director?
- Are current clinical protocol manual and MDCH Title X Family Planning Standard and Guidelines available at each site?
- Does the agency have an MDCH approved waiver for any requirement or required service not provided?

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Section X: Family Planning

- Do clients receive an explanation of all procedures and range of available services?
- Is a written general consent for services (covering exam and treatment) signed by the client prior to receiving any clinical services?
- Is the signed consent in the client's medical record?
- Are client return visits scheduled on an individualized basis depending upon the client's need for education, counseling and clinical care?
- Are protocols and operating procedures in place for referrals and follow-up including:
  - Referrals made as result of abnormal physical exam or laboratory findings?
  - Referrals for required services not provided on-site?
  - Referrals for services determined to be necessary buy beyond the scope of family planning?
- Does the agency have a written education plan?

Indicator 11.2

Client History and Physical Examination (7.2; 8.3)

To fully meet this indicator:

- Medical history must be obtained at the initial comprehensive clinical visit (female and male clients) including the following: **(7.2 E; 8.3 A)**
  - Personal Medical history
    - Significant illnesses (hospitalizations, surgery, blood transfusion/exposure to blood products (prior to 1984), and chronic or acute medical conditions.
    - Allergies
    - Current prescription/over-the-counter medications
    - Tobacco, Alcohol, other drug use
    - Immunizations
    - Review of systems
  - Female Reproductive Health
    - Contraceptive history, including adverse effects, reasons for discontinuing past methods
    - Menstrual history, including LMP
    - Sexual history
    - Obstetrical history
    - Gynecological conditions
    - Sexually transmitted infections, including HIV and HBV
    - Pap test history, including date of last Pap, abnormal results, treatment
    - In-utero exposure to diethylstilbestrol (DES)
  - Male reproductive history
    - Sexual history
    - Sexually transmitted infections, including HIV and HBV

Section X: Family Planning

    - Urological conditions
- Partner history of:
    - Injectable drug use
    - Multiple partners
    - Risk history for STI, including HIV
    - Sex with men, sex with women or both
- Pertinent history of immediate family members
    - Diabetes
    - Death from a heart attack before 50 y/o
    - High Blood Pressure
    - High blood fat levels (cholesterol)
    - Genetic problems/ birth defects
    - Cancer
    - Coronary Artery Disease

- Pertinent client history must be updated at subsequent physical exam visits. **(8.3G)**

- Clinics must provide and stress the importance of the following to all clients: **(8.3 B)**:
    - Blood pressure evaluation
    - Clinical breast exam (CBE), including instruction in breast self-awareness, beginning at age 21. Only as indicated for ages 13-20.
        - Every 3 years for ages 21-39 with average risk
        - Annually beginning at age 40, including information about mammogram recommendations
    - Pelvic exam, including vulvar evaluation and bimanual exam, as indicated beginning at age 21. Only as indicated for ages13-20
    - Pap smear, as indicated
    - Colo-rectal cancer screening, beginning at age 50
    - STI and HIV risk assessment and screening or referral, as indicated

- If a service is deferred or declined, both the counseling that took place and the reason for deferral must be documented in the client record. **(7.2 F.1; 8.3 B)**

Documentation Required:

- Service protocol and procedure manuals

- Access to client medical records

Evaluation Questions:

- Do all client histories (male and female) include Personal and family medical history and social history?

- Does the personal medical history review of systems include:
    - Cardiac problems
    - Cancer
    - Hypertension

Section X: Family Planning

- Blood clots/stroke
- Diabetes
- Hepatitis
- Epilepsy
- Hyperlipidemia
- Migraine Headaches?

- Is pertinent history updated at subsequent visits?

- Does the Physical examination for an initial and annual female exam include:
  - Blood pressure evaluation
  - Clinical breast exam, including instruction in breast self-awareness, beginning at age 21 or as indicated for 13-20 y/o.
    - Average risk 21-39 y/o every 3 years
    - 40 y/o and older annually and discuss mammogram recommendations
  - Pelvic exam, including vulvar evaluation and bimanual exam, as indicated beginning at age 21. Only as indicated for 13-20 y/o
  - Pap smear, as indicated
  - Colo-rectal cancer screening, beginning at age 50
  - STI and HIV risk assessment and screening or referral, as indicated?

- If clients decline or defer a service, are they counseled about the importance of preventive services?

- Is the reason for the deferral documented in the client medical record?

- Are there any deferrals of physical exam and preventive services beyond 6 months without a compelling reason documented by the clinician?

Indicator 11.3

Laboratory Testing and Medical Follow-up (7.4; 8.3 D; 10. 4 B.1)

To fully meet this indicator:

- Written laboratory protocols and operating procedures must be in place that include: **(8.3 D)**
  - Pregnancy testing must be provided on site as indicated.
  - Pap testing must be provided on site as indicated.
  - Agencies must comply with current MDCH Family Planning Pap test protocol.
  - STI and HIV testing, or referral for testing, as indicated
  - Colo-rectal cancer screening, beginning at age 50
  - Laboratory tests must be provided if indicated for a specific method of contraception

- Quality control, equipment maintenance and proficiency testing for on-site laboratory testing must be in place. **(8.3 D 8)**

- The agency must be in compliance with OSHA regulations regarding transmission of blood born disease. **(6.5.C.10)**

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Assurance of high quality lab testing for off-site labs, including CLIA compliance and license, must be in place. **(8.3 D 9)**

- Procedures must be established for referral and follow-up for abnormal tests that include: **(8.3 D 10)**
  - Notification/follow-up with client of significant lab results
  - Protection of client confidentiality
  - Referral for necessary services, if not provided on-site
  - Documentation of management in the client record

- There must be a tracking system that identifies clients in need of follow-up and/ or continuing care **(7.4 C.1,2; 10.4 B 1)**

- Written protocols for abnormal Pap testing follow-up must include: **(8.3 F. 1,2,3)**
  - Client notification must occur within 6 weeks
  - Referral follow-up through the BCCCP program must occur within 90 days of Pap testing
  - Follow up contact must be documented in the client record
  - Results of follow-up must be documented in the client record

- If STI testing is provided, agencies must have STI treatment protocols and follow-up procedures consistent with current CDC Guidelines **(8.3 D 11)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Appropriate CLIA certificate
- Laboratory logs
- Equipment maintenance logs
- Referral/Follow-up Logs

Evaluation Questions:

- Are all physical examination and laboratory tests required by the prescribing information for specific methods of contraception followed?
- Is GC and Chlamydia testing available for clients requesting IUD insertion, if indicated?
- Is Laboratory testing provided if indicated, including?
  - Anemia assessment, as indicated
  - Pap Smear, as indicated
  - Gonorrhea and Chlamydia test, as indicated

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Section X: Family Planning

- Pregnancy test, as indicated or requested
- Colo-rectal cancer screening, beginning at age 50
- STI and HIV testing or referral, as indicated

- Is there a tracking system that identifies clients in need of follow-up and/ or continuing care
- If STI and HIV testing is provided on site, are the protocols and procedures based on current CDC Guidelines?
- If treatment provided on site, do the protocols identify specific CDC treatment regimes provided in the clinic?
- When treatment is provided on site, is appropriate follow-up undertaken?
- Are state and local STD reporting requirements followed?
- Is the initiation and periodicity of Pap screening consistent with the current MDCH Family Planning Pap Test Protocol?
- Is there documentation of quality controls, equipment maintenance, and proficiency/competency for on-site laboratory testing?
- Is there documentation to assure high quality of off-site laboratory testing, including CLIA compliance?
- Are cytology services provided by laboratory compliant with state licensure regulations?
- Is there a written protocol for abnormal Pap smear follow-up that includes:
  - Client notification within six weeks?
  - Pap follow-up utilizing the BCCCP referral process must be completed within 90 days?
  - Follow-up contact is noted in the client's medical record?
  - Results of follow-up are noted in the client's medical record?
- Does the Client's medical record reflect:
  - Documentation of appropriate management for abnormalities?
  - Notification of the client?
  - Protection of client's confidentiality?
  - Follow-up with the client on significant lab results?
  - Referral for necessary services if not provided on site?
- Are infection control policies and procedures based on CDC recommendations, OSHA regulations and current medical practice followed?

Indicator 11.4

Medical Emergency/Situations and Equipment and Supplies (6.4; 7.3; 10.1. A, C)

To fully meet this indicator:

- There must be written protocols and procedures for the following emergency situations: **(7.3A; 6.4**)

Section X: Family Planning

- Vaso-vagal reactions/Syncope (fainting)
- Anaphylaxis
- Cardiac arrest
- Shock
- Hemorrhage
- Respiratory difficulties

- Protocols must be in place for emergencies requiring EMS transport, after hour's management of contraceptive emergencies and clinic emergencies **(7.3B)**

- All staff must be familiar with emergency procedures **(7.3 C)**

- Procedures for maintenance of emergency resuscitative drugs, supplies, and equipment must be in place **(7.3D)**

- Equipment and supplies must be safe, adequate and appropriate to the type of care offered by the project? **(10.1A)**

- Equipment maintenance and calibration must be performed and documented based on manufacturer instructions. **(10.1C)**

Documentation Required:

- Service protocol and procedure manuals

- Documentation of equipment maintenance

Evaluation Questions:

- Are there written plans/procedures/protocols to cover these emergency situations:
  - Vaso-vagal reactions/Syncope (fainting)
  - Anaphylaxis
  - Cardiac arrest
  - Shock
  - Hemorrhage
  - Respiratory difficulties?
- Are protocols in place for emergencies requiring EMS transport, after hour's management of contraceptive emergencies and clinic emergencies?
- Is all staff familiar with emergency procedures?
- Is a procedure in place for maintenance of emergency resuscitative drugs, supplies, equipment?
- Is equipment safe, adequate and appropriate to the type of care offered by the project?
- Does the agency have records documenting equipment maintenance and calibration checks (such as scales, sphygmomanometer, and microscope)?

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Indicator 11.5

Pharmaceuticals/Prescriptions (10.2)

To fully meet this indicator:

- Agencies must operate in accordance with Federal and State laws relating to security and record keeping for drugs and devices **(10.2)**
- Inventory, supply, and provision of pharmaceuticals must be conducted in accordance with Michigan state pharmacy laws and profession practice regulations. **(10.2)**
- Agencies writing prescriptions for Title X clients must follow the MDCH prescription policy including, **(10.2)**
  - Accepting a written prescription does not pose a barrier for the client
  - Prescriptions may only be written for items on the agency formulary
- All medications in Title X clinics must be pre-packaged. **(10.2A2a)**
- All prescriptions dispensed (including samples) must be labeled with the following: **(10.2A2b)**
  - Name/address of dispensing agency
  - Date of prescription
  - Name of the client
  - Name, strength, quantity of drug dispensed
  - Directions for use, including frequency of use
  - Prescriber name
  - Expiration date
  - Record number
- All clients receive verbal and written instructions for each drug dispensed. **(7.2H1) (10.2A2c)**
- All clients must be informed of danger signs and when and where to obtain emergency care and return scheduled follow up visits. **(7.2H2)**
- Contraceptive and therapeutic pharmaceuticals must be kept in a secure place, either under direct observation or locked**. (10.2A3di)**
- Access to the pharmaceuticals must be limited to health care professionals responsible for distributing these items **(10.2 A 3dii)**
- There must be a system in place to monitor expiration dates and ensuring disposal of all expired drugs. **(10.2A3e)**
- There must be a system in place for silent notification in case of drug recall. **(10.2A3f)**

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Section X: Family Planning

- There must be a current formulary (reviewed at least annually) that indicates: **(8.4.B5; 10.2.A4)**
  - Methods available on site
  - Methods available on site within 2 weeks
  - Methods available by paid referral
  - Methods available by unpaid referral

- There must be an adequate supply and variety of drugs and devices to meet client contraceptive needs? **(10.2A5)**

- There must be emergency drugs and supplies for the treatment of vaso-vagal reactions and anaphylactic shock, at each site where medical services are provided. **(10.2 A6a,b)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Pharmacy logs
- Inventory logs
- Formulary for Pharmaceuticals

Evaluation Questions:

- Are clinics in compliance with Federal and State laws that relate to the security and record keeping for drugs and devices?
- Are Inventory, supply, and dispensing practices in accordance with Michigan state pharmacy laws and profession practice regulations?
- Are all prescriptions given to Title X clients written only for items on the approved formulary?
- Are all medications pre-packaged?
- Are all prescriptions dispensed with a label that included the following items:
  - Name/address of dispensing agency?
  - Date of prescription?
  - Name of the client?
  - Name, strength, quantity of drug dispensed?
  - Directions for use, including frequency?
  - Prescriber name?
  - Expiration date?
  - Record number?

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Section X: Family Planning

- Do all clients receive verbal and written current instructions for each drug?
- Are all clients informed of danger signs and when and where to obtain emergency care and return scheduled follow up visits?
- Are contraceptive and therapeutic pharmaceuticals kept in a secure place, either under direct observation or locked?
- Is access to the pharmaceuticals limited to health care professionals responsible for distributing them?
- Is there a system in place to monitor expiration dates and ensuring disposal of all expired drugs?
- Is there a system in place for silent notification in case of drug recall?
- Is there a current formulary (reviewed at least annually) that lists
    - Methods available on site
    - Methods available on site within 2 weeks
    - Methods available by paid referral
    - Methods available by unpaid referral
- Is there an adequate supply and variety of drugs and devices to meet the client's contraceptive needs?
- Are emergency drugs and supplies for treatment of vaso-vagal reactions and anaphylactic shock available at each site where medical services are provided?

Indicator 11.6

Medical Records and Quality Assurance System (10.3; 10.4)

To fully meet this indicator:

- A medical record is established for all clients who receive clinical services, including pregnancy testing, counseling, and emergency contraception. **(10.3A1)**
- Medical records are: **(10.3A2)**
    - Complete, legible and accurate
    - Signed by clinician or health professional making each entry, including name, title and date
    - Readily accessible
    - Systematically organized to facilitate retrieval
    - Confidential
    - Safeguarded against loss or use by unauthorized persons
    - Secured by lock when not in use
    - Available to clients, upon request
- HIPAA regulations are followed. **(10.3A3)**

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Section X: Family Planning

- Medical records contain the following: **(10.3 B)**:
  - Personal data sufficient to identify the client:
    - name
    - unique client number
    - address
    - phone, how to contact
    - age
    - sex
    - marital status (Michigan requirement)
    - race & ethnicity (FPAR requirement)
    - Income assessment
  - Medical history
  - Physical exam
  - Documentation of clinical findings, diagnostic/therapeutic orders, including:
    - Lab test results and follow-up
    - Treatments initiated and special instructions
    - Continuing care, referral and follow-up
    - Scheduled revisits
  - Documentation of all medical encounters, including telephone encounters
  - Documentation of all counseling, education, and social services
  - Informed consent, including method specific consent
  - Contraceptive method chosen by the client

- A quality assurance system must be in place to provide ongoing evaluation of family planning services that includes: **(10.4 A; 10.4 B 3a; 10.4 B4a, 10.4 B13)**
  - Medical Audits to determine conformity with agency protocols and must be conducted monthly by the medical director
    - At least 2-3 charts per clinician must be reviewed by the medical director monthly**(10.4 B.3a)**
  - Chart Audits/Record Monitoring to determine completeness and accuracy of the medical record must be conducted monthly by the quality assurance committee or identified personnel
    - At least 3% of monthly caseload, randomly selected are reviewed monthly **(10.4 B.4a)**
  - A process to implement corrective actions when deficiencies are noted must be in place. **(10.4 B 13)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Documentation of Quality Assurance Medical Audits
- Documentation of Chart Audits and/or Record Monitoring
- Notes from Staff and/or Quality Assurance Committee meetings

Evaluation Questions:

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Is there a medical record for all clients who receive clinical services, including pregnancy testing, counseling, and emergency contraception?
- Are medical records complete, legible and accurate?
- Are all entries signed by the clinician or health professional including the name, title and date of entry?
- Is there a signature log, if name and title are not used for each entry?
- Are medical records readily accessible, systematically organized, confidential, and safeguarded against loss or unauthorized use?
- Are medical records secured by lock when not under staff surveillance or in use?
- Are medical records available to clients, upon request?
- Do medical records contain personal data sufficient to identify the client, including: name; client ID number; address; phone number; information on how to contact the client; age; sex; marital status (Michigan requirement); race & ethnicity (FPAR requirement); and income assessment?
- Do medical records contain documentation of all medical encounters: medical history; physical exam; documentation of all clinical findings including laboratory test results and follow-up; treatments initiated and special instructions; referrals and follow-up; and scheduled revisits.
- Do medical records contain documentation of all telephone encounters?
- Do medical records contain documentation of all counseling, education and social services?
- Do medical records contain informed consent, including method specific consents?
- Are medical audits regularly performed by the medical director to assure conformity with agency protocols?
  - Are medical audits conducted monthly by the Medical Director?
  - Do monthly medical audits review a minimum of 2-3 charts per clinician?
- Are Chart Audits/ Record Monitoring Audits to determine completeness and accuracy of medical records being conducted monthly by QA committee member or identified personnel?
  - Do chart audits represent a minimum of 3% of the agency monthly caseload?
  - Are chart audits topic audits, as suggested?
  - Are a reasonable number of randomly selected charts reviewed?
- Is there a process to implement corrective actions when deficiencies are noted?
- Are findings from medical and chart audits shared with staff on a regular basis?

Section X: Family Planning

MPR 12

Provide for social services related to family planning, including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(2)*

Indicator 12.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 M
- 7.2 C.1,2
- 7.4 D, F
- 8.2. (Counseling/counselor descriptors)
- 8.2 A. (Method counseling)
- 8.2. B. (STI/HIV counseling)

To fully meet this indicator:

- Counseling services must be provided either on-site or by referral **(3.4 M; 7.4 D)**
- Referral lists for social services agencies and medical referral resources must be current and reviewed annually. **(7.4 F; 7.4 F.1)**
- All clients must receive thorough and accurate counseling on STIs and HIV, including individualized risk reduction counseling. **(8.2.B)**
- The agency must offer education on HIV and AIDS, risk reduction information and either on-site testing by certified HIV counselors or referral for this service. **(8.2 B; 7.2 C.2)**
- Counseling must be provided by a counselor who is knowledgeable, objective, non-judgmental, sensitive to client differences and able to make the client comfortable. **(8.2)**
- Counselor must be knowledgeable to provide accurate information on the various contraceptive methods, STIs and HIV. **(8.2; 8.2 A1-9; 8.2 B)**
- The client counseling must be documented in the client's record. **(8.2)**

Section X: Family Planning

Documentation Required:

- Client medical records with counseling documentation
- Current referral list
- Written formal referral arrangements
- Agency protocol on providing counseling services

Evaluation Questions:

- Are agency counselors knowledgeable regarding contraceptive methods and sexually transmitted infections, including HIV?
- Are counseling services provided in an objective, non-judgmental and sensitive manner to clients?
- Are clients provided with counseling about the risk, prevention and offered voluntary HIV testing or referral for testing?
- Does the agency provide contraceptive method information and individualized counseling to all clients?
- Does the agency provide STI and HIV information and individualized counseling to all clients?
- Does the agency provide counseling services on site?
- Does the agency provide counseling services by referral?
- Is the agency's referral listing of social service agencies up to date?
- Does the agency maintain a current list of medical referral resources? Is the referral list reviewed annually?
- Does the agency have protocols for providing counseling services?
- Is all counseling, including STI/HIV, contraceptive, and adolescent counseling, documented in the client record?

Section X: Family Planning

MPR 13

Provide for informational and educational programs designed to: achieve community understanding of the objectives of the program; inform the community of the availability of services; and promote continued participation in the project by persons to whom family planning services may be beneficial.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(3)*

Indicator 13.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 N
- 6.9.1 A, C
- 6.9.2 A, B

To fully meet this indicator:

- The agency must submit an Annual Health Care Plan that includes written plans for: **(6.9.1; 6.9.2)**
  - Community education activities
  - Community project promotion activities
- The agency must include low-income women and teens in the target groups identified for program promotion activities. **(6.9.2 B.1)**
- The agency's plan for community education programs must include goals, objectives, and measurement criteria and should be based on an assessment of the needs of the service delivery area. **(6.9.1C)**

Documentation Required:

- Annual Health Care Plan
- Documentation of community education activities (such as, flyers, community meeting agendas, brochures, reports, logs)
- Documentation of activities program promotion activities (such as Outreach logs, news releases, articles, PSA's, and advertisements)
- Newsletters and other communications/educational tools as available

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Does the agency's Annual Health Care Plan have a written plan for program promotion with measurable objectives?
- Does the agency include low-income women and teens in the target group for program promotion activities?
- Does the agency's Annual Health Care Plan include a plan for community education activities?
- Does the agency provide an opportunity for community participation through various groups?

Section X: Family Planning

MPR 14

Provide for orientation and in-service training for all project personnel.

Reference: *42 CFR CH.1 (10-1-00 Edition) §59.5 (b)(4)*

Indicator 14.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 O
- 4.0 A
- 6.4
- 6.5.A 1-11
- 6.5. C 1-10
- 6.6 A. 3 & 6
- 7.0 C.1, 5 a, b
- 7.3 A, B, & E
- 9.2 B.4

To fully meet this indicator:

- The agency must meet applicable standards established by the Federal, state and local governments (e.g. local fire, building and licensing codes – non medical emergencies). **(6.4)**

- The agency must have written plans, protocols/operating procedures for non-medical situations, including fire, natural disaster, robbery, power failure, and harassment. **(6.4; 7.3 E)**

- The agency must have written personnel policies that comply with federal and state requirement and Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, and Title I of Americans with Disabilities Act (Public Law 101-336). These policies must cover the following required items: **(6.5.A1-11)**
  - Staff recruitment and selection methods
  - Methodology for performance evaluation
  - Staff promotion
  - Staff termination
  - Compensation and benefits
  - Grievance procedures
  - Staff orientation
  - Nondiscrimination in hiring employees
  - Patient confidentiality issues
  - Duties, responsibilities, and qualifications of each staff person
  - Licenses for those positions requiring licensure

- The agency must have a qualified family planning project coordinator. **(4.0 A; 6.5.C 1)**

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- All clinicians, including mid-level practitioners must maintain current licensure and certification, or approved waiver. **(6.5.C. 3a,b,c)**

- Personnel records are kept confidential **(6.5.C.4)**

- Organizational chart and personnel policies are available to all personnel. **(6.5.C.5)**
- The agency must have clinical personnel job descriptions and responsibilities clearly identified, reviewed annually, and updated as needed. **(6.5.C. 6)**

- Performance evaluations of all family planning personnel, including the medical director, are conducted per agency policy. **(6.5.C. 7**)

- The agency is in compliance with OSHA regulations regarding transmission of blood born disease. **(6.5.C.10)**

- The agency must provide for orientation and in-service training programs and should hold periodic staff meetings to review patient care activities. **(6.6.A)**

- The agency must train all staff in the prevention, transmission and infection control in the healthcare setting of sexually transmitted infections including HIV and blood born pathogen transmission. **(6.6.A.3; 6.5 C10; 9.2 B4)**

- The agency must provide in-service education pertaining to pharmaceuticals for staff involved in the provision of medications. **(10.2.A.2.d)**

- The agency must train staff in the unique social practices, customs, and beliefs of the under-served populations of their service area. **(6.6.A.6)**

- All licensed medical staff providing direct patient care must be trained in CPR and hold current certification. **(7.3 C)**

Documentation Required:

- Policies and/or procedures for non-medical emergencies, including fire, natural disaster, robbery, power failure, and harassment.

- Agency personnel policies

- Position Descriptions

- Copies of licenses for those positions requiring licensure

- Documentation of staff orientation, in-service training, and staff meetings
  - Staff training on the unique social practices, customs and beliefs of the under-served populations in their service area
  - Evidence of All staff trained in the prevention, transmission and infection control in the healthcare setting of sexually transmitted infections including HIV
  - Pharmaceutical training
  - CPR training and certification for all licensed medial staff providing direct care

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Section X: Family Planning

  - Staff training in emergency procedures and plans
  - Staff training on blood born pathogen transmission/OSHA training

- Documentation of staff continuing education

- Documentation of performance evaluations

Evaluation Questions:

- Does the agency keep written minutes of all meetings?

- Does the agency keep training records on each employee?

- Does the agency have an established procedure for providing orientation/in-service training to all new and current staff, including family planning program requirements, philosophy, policies and goals of operation?

- Is all staff trained in prevention, transmission and infection control in the healthcare setting of sexually transmitted infections including HIV?

- Is there documentation of training on blood born pathogen transmission/OSHA training?

- Have staff members involved in the provision of medications received pharmaceutical training?

- Is the program staff trained in the unique social practice, customs, and beliefs of the under-served population of their service area?

- Does the agency take advantage of the training available through regional training centers?

- Are personnel policies, position descriptions, and organizational chart available to staff?

- Are policies for non medical emergencies (fire, natural disaster, power failure, harassment) in place?

- Is staff aware of the non-medical emergency procedures in place?

Section X: Family Planning

MPR 15

Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

Reference: *2 CFR CH. I (10-1-00 Edition) §59.5 (b)(5)*

Indicator 15.1

See Michigan Title X Family Planning Standards & Guidelines 2011

3.4. P

To fully meet this indicator:

There is a written policy that services are provided without residency requirements or physician referral. **(3.4 P)**

Documentation Required:

- Non-discrimination policy for residency and physician referral
- Staff training protocol

Evaluation Questions:

- Is the policy included in staff orientation?
- Do the procedures support the policy?

Section X: Family Planning

MPR 16

Provide that the family planning medical services will be performed under the direction of a physician with special training or experience in family planning.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(6)*

Indicator 16.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 Q
- 6.5 C. 2, 3 & 8
- 10.2. A.2
- 10.4 B. 3,7

To fully meet this indicator:

- The medical director must be a licensed, qualified physician, with special training or experience in family planning. **(6.5 C.2)**
- The medical director approves and signs protocols and standing orders annually. **(6.5.C.3; 7.1;10.4.B.7)**
- Clinicians other than physicians performing medical functions do so under protocols and/or standing orders approved by the medical director. **(6.5.C.3; 6.5 C.8)**
- The medical director directs medical services and participates in quality assurance activities. **(3.4.Q;10.4.B.3)**
- Prescription of pharmaceuticals must be done under the direction of a physician who must have a drug control license for each clinic location in which storage and dispensing occurs. **(10.2 A.2)**

Documentation Required:

- Evidence that all mid-level providers have agreed to follow clinic procedures, protocols and standing orders signed and approved by the medical director
- Medical director's professional and drug control licenses for each clinic location
- Approved protocols and standing orders
- Curricula vitae of medical director

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Does the medical director:
  - Have a current medical professional license and special training and/or experience in family planning?
  - Direct the medical care component of the program?
  - Approve and sign protocols and standing orders on an annual basis?
  - Regularly review randomly selected medical records for each mid-level practitioner?
  - Are the mid-level practitioners evaluated annually by the medical director or peer review process?

- Is there a current drug control license (dispensing license) for each clinical location?

- Do all clinicians employed in the family planning program agree to follow clinic procedures, protocols and standing orders?

Section X: Family Planning

MPR 17

Provide that all services purchased for project participants will be authorized by the project director or his/her designee on the project staff.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(7)*

Indicator 17.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 6.1 (subcontracts)
- 6.2 (annual health care plan)
- 6.2 A.5 a (Title X Regulations 59.5)
- 6.3 (documentation and records)
- 7.1 (Service Plans, protocols, guidelines)
- 7.4 D.
- 10.1 B. & C.
- 10.2 A. 3

To fully meet this indicator:

- All services must be provided according to approved protocols. **(7.1)**
- Required services provided by referral must have formal arrangements with the referral provides that includes a description of the services provided and includes cost reimbursement information. **(7.4 D)**
- The current annual plan identifies all services to be provided. **(6.2. A.5)**
- Safeguards must be in place to assure that drugs purchased through the 340B program are only used for family planning clients. **(10.2A3diii)**
- There must be a proper segregation between requisition, procuring, receiving and payment functions for pharmaceuticals and supplies. **(10.2A 3 b)**
- There must be an inventory system to control purchase, use, reordering of pharmaceuticals and supplies. **(10.2 A 3c)**
- If a delegate agency subcontracts for services, a formal agreement consistent with Title X requirements must be current and have appropriate approval. **(6.1)**
- Documentation and records of all expenditures must be maintained. **(6.3)**
- The project coordinator, in consultation with the medical director, is responsible to assure proper selection and maintenance of equipment and supplies. **(10.1 B.)**

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Section X: Family Planning

- Appropriate MDCH procedures are followed for purchases and disposition of equipment costing $5,000.00 or more. **(10.1 D.)**

Documentation Required:

- Clinical Protocols
- Operating policies and procedures
- Required services provider agreements
- Annual Plan
- Subcontract agreements
- Records of pharmaceutical requisitions
- Documentation of Inventory system
- Records of equipment purchases over the past three years

Evaluation Questions:

- Are protocols approved, current and available at each site?
- Are formal agreements for required services provided by referral current and appropriately approved?
- Does the annual plan identify all services provided?
- Are subcontract agreements current and appropriately approved?
- Does the agency maintain appropriate documentation of all purchases, such as pharmaceuticals and equipment?
- Is there a division of duties within the agency between distributing, ordering, and stocking?
- Are drugs purchased in the 340B program only used for authorized 340B program clients?
- Is the medical director is involved in the selection of equipment and supplies?
- Are appropriate MDCH procedures followed for purchases and disposition of equipment costing $5,000.00 or more?

Section X: Family Planning

MPR 18

Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects support by other federal programs.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(8)*

Indicator 18.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 S.
- 7.4 (Referrals and Follow up)
- 8.3 D.10
- 9.1

To fully meet this indicator:

- The agency must have referral arrangements in place for the following: **(7.4)**
  - Referrals made as a result of abnormal physical exam or laboratory findings
  - Referrals for required services not provided on-site
  - Referrals for services determined necessary but beyond the scope of family planning

- Referral and follow up procedures must be sensitive to the client's concerns for confidentiality and privacy **(7.4.A)**

- Client consent for release of information to providers must be obtained, except as may be necessary to provide care or as required by law. **(7.4 B)**

- The agency must have written protocols/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These protocols must include a system to document referrals and follow up procedures, including: **(7.4 C.1,2; 8.3 D.10)**
  - A method to identify clients needing follow up
  - Notification of the client
  - A method to track follow up results on referrals
  - Documentation in the client record of contact and follow up
  - Documentation of reasons, actions where recommendations were not followed

- The agency must participate and refer clients to the Breast and Cervical Cancer Control Program (BCCCP) for client cervical cancer diagnostic services, as appropriate. **(9.1)**

- For services determined to be necessary but beyond the scope of family planning, clients must be referred to other providers for care, the agency must: **(7.4 E)**
  - Make arrangements for the provision of pertinent client information to the referral providers
  - Obtain client consent. Except as necessary to provide care or as required by law

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

  - Document that the client was advised of the referral and the importance of follow up
  - Document that the client was advised of their responsibility to comply with the referral
  - Maintain appropriate safeguards for confidentiality

- Referral lists for social services agencies and medical referral resources must be current and reviewed annually. **(7.4 F; 7.4 F.1)**

Documentation Required:

- Protocol/procedure for selecting and referring to other health care, local health and welfare departments, hospitals, voluntary agencies or health services projects
- Referral agreements between the agency and selected organizations providing minimally required services
- Current list of referral agencies
- Documentation of referrals and follow-up
- Client consent for release of pertinent information to referral agency

Evaluation Questions:

- Does the agency provide required services by referral?
- Do current referral agreements exist for minimally required services that detail reimbursement of cost with the referral agency?
- Do referral protocols/procedures include client consent for release of information?
- Is a system in place to document appropriate referrals have been made and follow-up has occurred as needed?
- Do referral protocols/procedures include follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings?
- Are referral protocols/procedures sensitive to clients' concerns for confidentiality and privacy?
- Does the agency maintain a current list of medical referral resources? Is the referral list reviewed annually?
- Is there a system that provides the client an explanation for the referral
- Does the agency participate in the BCCCP program?

Section X: Family Planning

MPR 19

Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payments procedures maintained by the agency. The agency must be prepared to substantiate that these rates are reasonable and necessary.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(9)*

Indicator 19.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4. T
- 7.4 D
- 6.1

To fully meet this indicator:

- The agency must have in place formal arrangements regarding provision of services and reimbursement of costs for contractual services. **(3.4.T; 7.4.D; 6.1)**

Documentation Required:

Copies of contractual agreements for family planning services purchased.

Evaluation Questions:

- Are formal agreements in place with contractual providers such as physicians, nurse practitioners, medical directors, or other staff who are not agency employees?
- Do agreements with contractual providers include payment arrangements?

Section X: Family Planning

MPR 20

Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(10)*

Indicator 20.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 U
- 6.9. A, B, D

To fully meet this indicator:

- The agency must provide an opportunity for participation in the development, implementation, and evaluation of the project. **(6.9 A.)**
- The agency plan must include plans for community participation. **(6.9 B, D.)**

Documentation Required:

- Community participation plan section of the Annual Plan.
- Documentation that plan has been accomplished, as appropriate.

Evaluation Questions:

- Does the agency's annual plan include a plan for community participation?
- Does the agency provide an opportunity for community participation in the development, implementation, and evaluation of the project by persons knowledgeable about the community's need for family planning participation?
- Are persons from significant elements of the service population participating?

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

MPR 21

Any funds granted shall be expended solely for the purpose of delivering Title X Family Planning Services in accordance with an approved plan & budget, regulations, terms & conditions and applicable cost principles prescribed in 45 CFR Part 74 or Part 92, as applicable.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.9*

Indicator 21.1

See Michigan Title X Family Planning Standards & Guidelines 2011

- 3.4 V
- 6.3
- 6.3.1. A – L
- 6.3.2. B & C
- 6.3.3. (Financial audit)

To fully meet this indicator:

- The agency must have a separate budget for Title X funds. **(3.3 E; 6.3)**
- The agency budget must be developed and approved annually by MDCH. **(3.3 E)**
- The agency must maintain a financial management system that meets the standards specified in 45CFR 74.21 or 45CFR 92.20 and is in compliance with federal standards. **(6.3)**
- The agency must have an annual financial audit conducted in accordance with provisions of 45CFR PART 74, Subpart C, and 45 CFR PART 92, Subpart C, as applicable and with federal OMB Circular A-133. **(6.3.3)**
- The agency's FPAR Table 14 must be compiled using current financial data and must be accurate and complete. **(6.3.2)**
- The agency's FPAR Table 14 must show income from Title XIX (Medicaid) and must report voluntary donations as other revenue. **(6.3 2 B & C)**

Documentation Required:

- Budget/CPBC
- Financial Status Report
- Ledger
- Financial audit

For technical assistance, contact Jeanette Lightning at 517-335-9263 or lightningj@michigan.gov or Sharon Karber (clinician) at 517-335-8910 or karbers@michigan.gov

Section X: Family Planning

- Contracts
- Family Planning Annual Report
- Completed Pre-visit Fiscal Review Questionnaire

Evaluation Questions:

- Are the Title X funds distinguishable from other budgeted funds?
- Does the agency have written financial audits?
- Have financial audit/findings been corrected/addressed?
- Do the agency financial reports indicate appropriate expenditures as outlined in the budget?
- Are all sources of funds identified in the operating budget?
- Does the agency's FPAR Table 14 show income from Medicaid Title XIX and voluntary donations?

Section XI: Women, Infants, and Children Administration (WIC)

MPR 1

The WIC Management Evaluation and Corrective Plan of Action (as required) are conducted and satisfactorily completed on a biennial basis as mandated by the United States Department of Agriculture.
(7 CFR 246.9(a), WIC Policy 1.05)

Indicator 1.1

The previous WIC Management Evaluation Review (12 Months prior to the Accreditation Date) and its follow-up Corrective Plan of Action is successfully completed, near completion or progressing toward completion; or there were no citations found during the Management Evaluation Review. (7 CFR 246.9 (a), WIC Policy 1.05)

This indicator may be met by:

The WIC Management Evaluation (ME) must have all Met Indicators, or the WIC ME Corrective Plan of Action for each of the indicators must be Met/Completed.

See WIC 2014 Schedule for applicable WIC Management Evaluation, WIC Follow-Up Corrective Plan of Action.

Documentation Required:

Management Evaluation status letter indicates all indicators MET.

Final ME Follow up Review Corrective Plan of Action letter shows all indicators MET or complete.

Evaluation Questions:

- Are all WIC Management Evaluation indicators Met?
- Are all WIC ME Corrective Plan of Action indicators met or completed?

To access the 2011 Management Evaluation Review Tools, please use this web address:
http://www.michigan.gov/mdch/0,1607,7-132-2942_4910_19205_21312-256470--,00.html

For technical assistance, please contact Terri Riemenschneider at 517-335-9562 or riemenschneidert@michigan.gov or Jean Egan at 517-241-6248 or eganj@michigan.gov

Section XII: Children's Special Health Care Services (CSHCS)

MPR 1

The local health department (LHD) Children's Special Health Care Services (CSHCS) program shall assure that adequate, trained personnel are available to provide outreach, enrollment and support services for children and youth with special health care needs (CYSHCN) and their families.

Reference: *CSHCS Guidance Manual for Local Health Departments, Standard of Practice.*

Indicator 1.1

LHD CSHCS shall maintain a staffing configuration that includes a Registered Nurse and a program representative to provide program services to CSHCS client caseload.

This indicator may be met by:

There shall be evidence that the staffing is adequate to provide the required program services to the community and caseload. The table below provides recommended staffing levels based on caseload. The staffing levels in this table are the historical recommendations associated with CSHCS; however, it is incumbent on each LHD to determine the appropriate staffing levels/configuration to meet the needs of the community and of the CSHCS enrolled caseload.

Caseload Ranges	Recommended Registered Nurse FTE	Recommended Program Representative FTE
<150	.25	.25
150-400	.50	.25-.50
401-600	1.0	.50
601-800	1.0-1.5	1.0
801-1,300	2.0	1.0-1.5
1,301-2,000	2.0-2.5	1.5-2.0
2,001-2,800	3.0	2.0
2,801-3,300	5.0	5.0
>3,300	6.0	6.0

Documentation Required:

All below are required.

- Roster indicating the LHD CSHCS staffing configuration. Materials should be submitted in advance of the review.
- On-site interview describing how the LHD CSHCS staffing configuration adequately meets the needs of the community (outreach/case-finding) and of the CSHCS enrolled caseload.

Evaluation Question:

Does the LHD staffing configuration allow the LHD to provide quality, CSHCS-required services?

For technical assistance, please contact Matt Richardson (RichardsonM@michigan.gov) at 517-335-8994 or Courtney Pendleton (pendletonc@michigan.gov) at 517-241-7189

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 1.2

The LHD shall submit a CSHCS staff roster to the MDCH CSHCS program and shall notify the MDCH within 30 days when changes to the roster occur.

This indicator may be met by:

There shall be evidence of a current, accurate staff roster. If changes have been made to the staffing, documentation exists showing that the revised roster was sent to MDCH within the 30 day time frame.

Documentation Required:

All below are required.

- A current roster that matches the reported and observable staffing.

If changes occur the following are also required:

- Dated correspondence (electronic or written) that the staff roster was submitted to MDCH initially and within required time frame following changes to staffing. Materials should be submitted in advance of the review.

- Personnel records indicating when staffing changes occurred as compared to submission of roster to MDCH.

Evaluation Question:

Is the LHD CSHCS Program maintaining an accurate CSHCS staff roster and communicating changes in staffing to MDCH in a timely manner?

Indicator 1.3

New LHD CSHCS employees shall take both the "What is Children's Special Health Care Services" and "LHD Orientation" on-line courses within 90 days of employment. All LHD CSHCS staff shall take these courses within 90 days of notification that the training courses have been updated.

This indicator may be met by:

There shall be evidence that exists of timely staff training using the "What is Children's Special Health Care Services" and "LHD Orientation" on-line courses within the specified timeframes.

Documentation Required:

All below are required.

- Written policy and procedure delineating staff training of new and on-going employees.

- Printed certificate of completed "What is Children's Special Health Care Services" on-line training including name and date. Materials should be submitted in advance of the review.

For technical assistance, please contact Matt Richardson (RichardsonM@michigan.gov) at 517-335-8994 or Courtney Pendleton (pendletonc@michigan.gov) at 517-241-7189

Section XII: Children's Special Health Care Services (CSHCS)

- Dated notation in the employee's personnel record by the supervisor that the "LHD Orientation" on-line course has been taken (no printable certificate available for this training). Materials should be submitted in advance of the review.

Evaluation Question:

Are LHD CSHCS program staff oriented timely and then updated as needed to the CSHCS program through use of the CSHCS "What is Children's Special Health Care Services" and "LHD Orientation" on-line course?

Indicator 1.4

LHD CSHCS program shall designate at least one person from each county to attend CSHCS state-office regional meetings.

This indicator may be met by:

There shall be evidence of routine staff training/updating through attendance at the CSHCS sponsored regional LHD meetings by at least one person from each county.

Documentation Required:

All below are required.

- Staff roster with county assignment as compared to the CSHCS regional meeting sign-in sheet showing registrants and attendees (signature of attendees).

- If attendee neglected to sign in, other evidence of attendance as possessed by attendee/LHD.

Evaluation Question:

Did at least one CSHCS staff person from each county attend MDCH sponsored CSHCS regional meetings?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 2

In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.

Reference: *HIPAA, CSHCS Guidance Manual for Local Health Departments, Standard of Practice.*

Indicator 2.1

The LHD CSHCS program staff shall routinely use the CSHCS On-Line database to securely manage CSHCS client PHI and effectively and efficiently coordinate care.

This indicator may be met by:

There shall be evidence of proficient and regular use of the CSHCS On-Line database by all LHD CSHCS program staff to successfully carry out local CSHCS functions.

Documentation Required:

All below are required.

- Written policy and procedure delineating use of the CSHCS On-Line database to carry out daily functions.

- During onsite reviews LHD staff will be asked to demonstrate proficiency with the database by showing reviewers how to find one or more of the following pieces of information using the CSHCS On-Line database:
    - Client look-up
    - Medical report received date
    - Medical report approved date
    - Listing of approved providers
    - Renewal information
    - Where to find MDCH/CSHCS notes
    - Client eligibility begin/end dates
    - How to print county-specific reports

Evaluation Questions:

- Are the LHD staff using the CSHCS On-Line database regularly and accurately to efficiently, effectively and securely obtain the information necessary to carry-out their daily functions such as communicating with CSHCS-enrolled clients and/or their families and coordinating CSHCS client care?

- Are policy and procedures in place that include use of the CSHCS On-Line database?

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Indicator 2.2

The LHD CSHCS program staff shall use the secure electronic method of communication for sharing of PHI designated by CSHCS (e.g. EZ-Link).

This indicator may be met by:

There shall be evidence of proficient and regular use of the designated electronic system for sharing PHI, by the appropriate LHD CSHCS program staff to successfully carry out CSHCS functions.

Documentation Required:

All below are required.

- Written policy and procedure delineating use of the designated electronic data system for secure sharing of CSHCS PHI to carry out daily functions.
- Evidence of use of this data system (system "footprints" of use).

Evaluation Questions:

- Are the LHD staff regularly and accurately using the designated electronic system for sharing PHI to efficiently, effectively and securely share the information necessary to carry-out their daily functions including communicating with MDCH and coordinating CSHCS client care?
- Are policy and procedures in place that includes use of the designated electronic data system for sharing PHI?

Indicator 2.3

LHD CSHCS shall have a shared, comprehensive client record for CSHCS enrollees that reflects communication among the staff and includes dates and staff identifier.

This indicator may be met by:

There shall be evidence that the LHD maintains comprehensive client record on all CSHCS enrollees that all local CSHCS staff use to record contacts and document services provided.

Documentation Required:

All below are required.

- Physical evidence of comprehensive client records exists. The previous year's activities in client charts should be submitted in advance of the review (individual clients will be specified by MDCH).
- Evidence that all CSHCS staff record contacts/CSHCS services in one client record including date of interaction and staff identifier.
- Evidence of referrals within the program (CSHCS program representative referring to CSHCS nurse and vise versa).

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Evaluation Questions:

- Does the LHD CSHCS program maintain shared client records (all staff document in one, comprehensive client record)?
- Do the chart notations indicate communication among the CSHCS staff to ensure coordination of care for the CSHCS client?
- Do all client record notations include a date and staff identifier?

Indicator 2.4

LHD CSHCS shall only access the minimum information necessary in the CSHCS On-Line database or other electronic data systems to complete tasks for CSHCS clients.

This indicator may be met by:

There shall be evidence that LHD CSHCS staff implement the privacy provisions of HIPAA in carrying out their CSHCS tasks using the CSHCS electronic data systems and that staff receive the local health department's policy and procedure regarding HIPAA compliance.

Documentation Required:

All below are required.

- Evidence that HIPAA compliant LHD policy and procedures have been shared with LHD CSHCS staff.
- Written policy and procedure delineating HIPAA compliant use of the CSHCS On-Line database.
- The LHD maintains on file a copy of signed and dated HIPAA agreement to comply form by each staff member. Materials should be submitted in advance of the review.
- On-site interview of how LHD CSHCS staff uses the data systems in a HIPAA compliant manner.

Evaluation Questions:

- Have the LHD CSHCS staff received the LHD policy and procedure regarding HIPAA compliance?
- Have the LHD CSHCS staff been informed of HIPAA rules regarding privacy and have they signed an agreement to comply with these rules?

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Section XII: Children's Special Health Care Services (CSHCS)

Indicator 2.5

LHD CSHCS shall offer families a private location for the exchange of confidential information.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program has a private location and it is offered to CSHCS families where they can privately exchange confidential information.

Documentation Required:

All below are required.

- Written policy and procedure delineating how families are offered a private location to share confidential information with the LHD CSHCS staff.
- Physical evidence of a private location.
- On-site interview of how/when LHD CSHCS staff offer CSHCS clients and/or families the opportunity to discuss confidential information in a private location.

Evaluation Question:

Does the LHD CSHCS program have a private location for discussion of confidential information with CSHCS clients and/or families and is it routinely offered to them?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 3

The local health department CSHCS program shall have family-centered policies, procedures and reporting in place.

Reference: *(CSHCS Guidance Manual for Local Health Departments, Standard of Practice, Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB), Sec. 501 of Title V of the Social Security Act, MCHB Performance Indicator).*

Indicator 3.1

LHD CSHCS shall regularly use the most current Children's Special Health Care Services Guidance Manual for Local Health Departments (Guidance Manual) to effectively and consistently carry out local program expectations, policies and requirements.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program staff routinely use the CSHCS Guidance Manual in carrying out local program expectations, policies and requirements.

Documentation Required:

All below are required.

- Written policy and procedure delineating how the LHD uses the most current Guidance Manual.
- On site interview will include having all LHD CSHCS staff demonstrate their proficiency with the Guidance Manual by showing reviewer(s) how to find one or more pieces of information in the Guidance Manual as indicated by the reviewer(s).

Evaluation Question:

Has the local health department demonstrated compliance and competence in routinely using the current CSHCS Guidance Manual?

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Indicator 3.2

LHD CSHCS shall have written policies and procedures in accordance with CSHCS published policy that are reviewed annually and updated as needed regarding local CSHCS program functions.

This indicator may be met by:

There shall be evidence of written policies and procedures (electronic or hard-copy) that stipulate local procedures in accordance with current CSHCS published policy. NOTE: the list that follows includes the minimum, required written policies and procedures. Greater detail is included within each specified minimum program requirement throughout this document. There shall be evidence that the written policies and procedures are reviewed annually and updated as necessary and include at a minimum:

1. staff training of new and on-going employees. (Indicator 1.3)
2. use of the CSHCS On-Line data-base to securely manage CSHCS PHI and effectively and efficiently coordinate care. (Indicator 2.1)
3. use of the designated electronic data system for secure sharing of CSHCS PHI to carry out daily functions. (Indicator 2.2)
4. HIPAA compliant use of the CSHCS On-Line database. (Indicator 2.4)
5. how families are offered a private location for exchange of confidential information with the LHD CSHCS staff. (Indicator 2.5)
6. how the LHD CSHCS staff use the most current Guidance Manual. (Indicator 3.1)
7. how and when family input is obtained. (Indicator 3.3)
8. CSHCS rights and responsibilities and how clients/families are informed of their rights and responsibilities and when. (Indicator 3.4)
9. how the data, required for the November 15th annual report is collected, compiled, submitted by the specified date. (Indicator 3.5)
10. how outreach to families and the community is conducted. (Indicator 4.1)
11. how and what outreach materials are disseminated to families and the community. (Indicator 4.1)
12. referral process including information about available community resources for LHD clients with special health care needs but not enrolled in CSHCS. (Indicator 4.2)
13. how/when diagnostic evaluations are issued and documented. (Indicator 4.3)
14. how/when families are informed and/or referred to the Family Center, Family Phone Line and Family Support Network as appropriate. (Indicator 4.4)
15. how assistance is provided to families who are referred or who contact the LHD directly in completion of the CSHCS application process and/or forms. (Indicator 5.1)
16. the manner in which families who have not returned the CSHCS application within 30 days of invitation are located, how the ones who are located are contacted, the number of attempts made when contacting families, the process by which assistance is offered and how these attempted and successful contacts are documented. (Indicator 5.2)
17. how the LHD CSHCS program follows up with those with a temporary eligibility period (TEP). (Indicator 5.3)
18. how assistance is provided to families in applying for other programs. (Indicator 5.4)
19. the process for the contact at initial enrollment (who, what and when) including but not limited to general CSHCS program information and a description of CSHCS benefits applicable to the current client/family circumstances, as well as other related programs/benefits. (Indicator 6.1)

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20. the process for annual contact (who, what and when) which includes at a minimum, updated information about the CSHCS program, benefits, assessment of client/family needs and collection of updated client/family information. (Indicator 6.1)
21. how assistance is provided to enrolled clients/families addressing their care and services needs. (Indicator 6.2)
22. how assistance is provided to CSHCS clients who are aging-out of CSHCS and enrolling/transitioning in a MHP. (Indicator 6.3)
23. how assistance is provided to clients who are nearing identified transition ages. (Indicator 6.4)
24. how assistance is provided to clients/families in need of in-state transportation. (Indicator 6.5)
25. how in-state transportation is authorized for clients/families in accordance with CSHCS published policy and LHD Guidance Manual. (Indicator 6.5)
26. how assistance is provided to clients/families in need of out-of-state care and out-of-state transportation. (Indicator 6.6)
27. how Level I and Level II care coordination services are provided to clients/families when needed. (Indicator 6.7)
28. how case management services are made available to clients/families when needed. (Indicator 6.7)

Documentation Required:

All below are required.

- Written policies and procedures delineating the specified, required procedures at a minimum. Materials should be submitted in advance of the review.
- Dated notation of annual review and revisions as necessary.

Evaluation Questions:

- Does the local health department have written policies and procedures of local functions that are reviewed annually and updated as necessary?
- Do the policies and procedures include the required, minimum procedures?
- Are the policies and procedures in accordance with current CSHCS published policy?

Indicator 3.3

LHD CSHCS shall facilitate the direct participation of families in the local CSHCS program development, evaluation and policy formation, at least annually.

This indicator may be met by:

There shall be evidence of recruitment of family involvement for input, feedback and recommendations regarding possible improvements to the overall local CSHCS program.

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Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how and when family input is obtained.

Example of further documentation needed that meet the requirement, including but not limited to.

- Copies of outreach to families e.g., family survey documents and results, satisfaction surveys, focus groups, meeting notes etc. Materials should be submitted in advance of the review.
- On-site interview that indicates how family input is obtained and the outcome of family input.

Evaluation Question:

Has the local health department elicited input from local families regarding the operation of the CSHCS program at the local level and how it could be improved?

Indicator 3.4

LHD CSHCS shall inform families of their rights and responsibilities in the CSHCS program and must include at a minimum the information contained in the CSHCS model found in the Guidance Manual.

This indicator may be met by:

There shall be evidence that families have been informed of their rights and responsibilities regarding the CSHCS program.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the CSHCS rights and responsibilities and how clients/families are informed of their rights and responsibilities and when.

Example of further documentation needed that meet the requirement, including but not limited to.

- Dated client chart notation that rights and responsibilities were shared with the family and staff identifier.
- Copy of written document given to families.
- Evidence of it being posted.
- On-site interview that indicates how families are informed of their rights and responsibilities.

Evaluation Questions:

- Does the LHD CSHCS program inform clients/families of their rights and responsibilities regarding the CSHCS program?

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- Do the rights and responsibilities include the required minimum elements as found in the Guidance Manual?

Indicator 3.5

By November 15 following the end of the fiscal year, the local health department CSHCS program shall report the duplicated number of clients referred for diagnostic evaluations, the unduplicated number of CSHCS eligible clients assisted with CSHCS enrollment, and the unduplicated number of CSHCS clients assisted in the CSHCS renewal process.

This indicator may be met by:

There is evidence that the CSHCS LHD program submitted the data report including the required data elements by the specified date in accordance with following element definitions:

Duplicated Number of Clients Referred for Diagnostic Evaluation is defined as: Number of individuals the local health department (LHD) referred for and/or assisted in obtaining a diagnostic evaluation during the fiscal year. Those eligible for this service must have symptoms and medical history indicating the possibility of having a CSHCS qualifying condition that cannot be determined from existing medical information. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP) or with other commercial insurance coverage must seek an evaluation by an appropriate physician sub-specialist through their respective health insurer. A diagnostic may be issued for insured persons to cover the cost of the evaluation that is by policy not covered by the health insurance (e.g. co-pay, deductible).

Unduplicated Number of CSHCS Eligible Clients Assisted with CSHCS Enrollment is defined as: Number of CSHCS eligible clients the LHD assisted in the CSHCS enrollment process during the fiscal year. This assistance includes but is not limited to helping the family obtain necessary medical reports to determine clinical eligibility, completing the CSHCS Application for Services, completing the CSHCS financial assessment forms, etc. "Assisted" refers to help provided either over the telephone or in person with the client.

Unduplicated Number of CSHCS Clients Assisted in the CSHCS Renewal Process is defined as: Number of CSHCS enrollees the LHD assisted in the completion and/or submission of the documents required for MDCH to make a determination whether to continue/renew CSHCS coverage during the fiscal year. "Assisted" refers to help provided either over the telephone or in person with the client.

Documentation Required:

All below are required.

- Written policy and procedure delineating how the data, required for the November 15th annual report, is collected, compiled and submitted within the specified timeframe.

- MDCH receipt of data report within the required timeframe and including the required elements.

Evaluation Question:

Does the LHD CSHCS program submit the data report as required within the specified time?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 4

The local health department CSHCS program shall provide outreach, case-finding, program representation and referral services to CYSHCN/families in a family-centered manner and to community providers.

Reference: *MCHB Performance Measures, Michigan Public Health Code, 333.5805 (1) a.*

Indicator 4.1

LHD CSHCS shall routinely conduct outreach/case finding and program representation which includes, but is not limited to, the provision of information regarding CSHCS policy on diagnostic referrals, program eligibility, and covered services, to families, local hospitals, providers, the community and other agencies.

This indicator may be met by:

There shall be evidence of outreach, case-finding and program representation to families and community organizations.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how outreach to families and the community is conducted.
- Written policy and procedure delineating how outreach materials are disseminated to families and the community.

Example of further documentation needed that meet the requirement, including but not limited to.

- Agendas for meetings held with hospitals or other community agencies. Materials should be submitted in advance of the review.
- Sign-in sheets including title of meeting, location and date. Materials should be submitted in advance of the review.
- Copies of letter inviting/confirming attendance at community functions or meetings. Materials should be submitted in advance of the review.
- Log sheet summarizing outreach efforts. Materials should be submitted in advance of the review.
- On-site interview that indicates how outreach, case-finding and program representation to families and community organizations are accomplished. Materials should be submitted in advance of the review.

Evaluation Question:

Does the LHD CSHCS program provide the required outreach, case-finding and program representation to families and organizations/providers in the community?

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Indicator 4.2

LHD CSHCS shall refer CYSHCN and CSHCS clients to other needed services/programs.

This indicator may be met by:

There shall be evidence of referral procedures and practices for families of CYSHCN and those enrolled in the CSHCS program.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating referral process including information about available community resources for LHD clients with special health needs but not enrolled in CSHCS.

Example of further documentation needed that meet the requirement, including but not limited to.

- Dated client chart notation in the comprehensive client chart and/or on the plan of care for clients enrolled in CSHCS including staff identifier.
- On-site interview that indicates when and how families of CYSHCN as well as of CSHCS are referred to other needed services/programs.

Evaluation Question:

Does the LHD CSHCS program refer CSHCS clients as well as clients with special health needs who are not enrolled in CSHCS to other needed programs and services?

Indicator 4.3

LHD CSHCS shall arrange diagnostic evaluations in accordance with CSHCS published policy and assist with Release of Information form(s) to secure medical reports for purposes of determining CSHCS medical eligibility.

This indicator may be met by:

There shall be evidence of referral of clients/families for diagnostic evaluations following the required MDCH procedure and assisting families in the process of getting appropriate medical records sent to CSHCS to determine CSHCS medical eligibility.

Documentation Required:

All below are required.

- Written policy and procedure delineating how/when diagnostic evaluations are issued and documented.
- Electronic or hard copy of the CSHCS Diagnostic Form (MSA-0650(E)).

Section XII: Children's Special Health Care Services (CSHCS)

- Electronic or hard copy of the LHD Release of Information (or notation indicating date issued and to whom).

Evaluation Question:

Does the LHD CSHCS program arrange diagnostic evaluations following CSHCS published policy and assist with Release of Information forms on behalf of clients/families to determine CSHCS medical eligibility?

Indicator 4.4

LHD CSHCS shall refer all families to the CSHCS Family Center for Children and Youth with Special Health Care Needs (Family Center). All written documents sent to families from the LHD shall contain the Family Phone Line toll-free number and the CSHCS website (www.michigan.gov/cshcs).

This indicator may be met by:

There shall be evidence of referral of clients/families to the Family Center, to include the Family Phone Line and Family Support Network when appropriate as well as inclusion of the required information on all family-focused materials and correspondence to families.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how/when families are informed and/or referred to the Family Center, which includes referral to the Family Phone Line and Family Support Network as appropriate.

- Family correspondence and public relations materials contain the Family Phone Line number and the CSHCS website. Materials should be submitted in advance of the review.

Example of further documentation needed that meet the requirement, including but not limited to.

- Dated client chart notation including staff identifier.
- Plan of care.
- Checklist.
- Annual update.
- Family correspondence.

- On-site interview that indicates when and how families receive information and referral to the Family Center.

Evaluation Questions:

- Does the LHD CSHCS program refer all families to the Family Phone Line, Family Center and the Family Support Network as appropriate?

- Has the LHD CSHCS program included the Family Phone Line toll-free number and the CSHCS website on all written correspondence and documents developed for families?

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Section XII: Children's Special Health Care Services (CSHCS)

MPR 5

The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

Reference: *Michigan Public Health Code 333.5805, 333.5817, CSHCS Guidance Manual for Local Health Departments.*

Indicator 5.1

LHD CSHCS shall assist any family who is referred to or who contacts the local health department with needs regarding completion of CSHCS application processes and/or forms.

This indicator may be met by:

There shall be evidence that the LHD CSHCS has assisted families who have been referred or who have contacted the LHD for help with the CSHCS application process and/or forms.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure which includes assisting families who are referred or who contact the LHD directly in the completion of the CSHCS application process and/or forms.

Example of further documentation needed that meet the requirement, including but not limited to.

- Dated client chart notation documenting assistance provided to the client/family in completing the application and/or forms and staff identifier.
- Check box on application indicating LHD assisted with the CSHCS application.
- On-site interview that indicates how the LHD works with families who are referred or who contact the LHD for help with the CSHCS application process and/or forms.

Evaluation Question:

Does the LHD CSHCS program assist clients/families who are referred or who contact the LHD with the CSHCS application process and/or other form completion as needed?

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Indicator 5.2

LHD CSHCS shall locate individuals or families who do not return a CSHCS Application within 30 days after being invited to join CSHCS, to offer assistance with application completion.

This indicator may be met by:

The LHD CSHCS program shall have evidence of attempting to locate those who have not returned an application within 30 days of being invited to join CSHCS and of offering to assist with completing the application.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the manner in which families who have not returned the CSHCS application within 30 days of invite, are located, how the ones who are located are contacted, the number of attempts to be made when contacting families, the process by which assistance is offered, and how these attempted contacts and successful contacts are to be documented.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Use of Notice of Action Application Follow-Up Report and notations of follow-up activities indicating multiple attempts to contact.
- On-site interview that indicates how attempts are made to locate families who have not returned the CSHCS application and how assistance is offered.

Evaluation Questions:

- Does the LHD CSHCS program adequately attempt to locate individuals or families who do not return a CSHCS Application within 30 days after being invited to join CSHCS?
- Does the LHD CSHCS program offer assistance with application completion to the families that have been located?

Indicator 5.3

LHD CSHCS shall assist clients/families who have received a CSHCS 90-day temporary eligibility period (TEP).

This indicator may be met by:

There is evidence that the LHD CSHCS program contacts families that have a TEP and offers/provides assistance during their 90 day TEP to avoid loss of CSHCS coverage.

Section XII: Children's Special Health Care Services (CSHCS)

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how the LHD CSHCS program follows up with those with a TEP.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Evidence the LHD is maintaining and using the MDCH/CSHCS TEP letter and/or Client Eligibility Notice showing 90 day coverage to identify those who may need assistance.
- Dated client chart notation documenting contact with families that have TEP coverage within 30 days of receipt of MDCH letter.
- Evidence of in-person or over-phone assistance provided to the family to complete the requirement that will extend the CSHCS coverage beyond 90 days.
- On-site interview that indicates how the LHD contacts families who have received a TEP and offers/provides assistance to avoid the loss of CSHCS coverage.

Evaluation Question:

Does the LHD appropriately assist families in completing the TEP process prior to the 90 day deadline?

Indicator 5.4

LHD CSHCS shall assist persons in making applications for other programs in the community for which the child and/or family may be eligible, such as Early On, WIC, MIChild, Healthy Kids, Medicaid, SSI and Medicare.

This indicator may be met by:

The LHD CSHCS shall have evidence of assisting families in applying for other programs for which they might be eligible such as Early On, WIC, MIChild, Healthy Kids, Medicaid, SSI and Medicare.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to families in applying for other programs.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated client chart notation documenting application assistance and staff identifier.
- Information regarding other program application assistance in the client's Family Needs Summary Checklist.
- Information regarding other program application assistance in the individual plan of care.
- On-site interview that indicates how the LHD assists families in applying for other programs that the client/family may be eligible.

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Evaluation Question:

Does the LHD CSHCS program assist families in applying for other programs such as Early On, WIC, MIChild, Healthy Kids, Medicaid, SSI and Medicare?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 6

The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families.

Reference: *HRSA/MCHB Sec. 501 of Title V of the Social Security Act, MCHB Performance Indicators. Michigan Public Health Code 333.5805.*

Indicator 6.1

LHD CSHCS shall initiate contact to inform CSHCS clients/families of applicable CSHCS and related benefits upon enrollment and as needed according to individual circumstances. Following initial enrollment, CSHCS enrolled families shall be contacted at least annually to provide updated information about the CSHCS program, benefits, and assess family needs and update client information.

This indicator may be met by:

There shall be evidence that, at enrollment, the LHD initiates a contact with CSHCS clients/families and informs them about CSHCS and the CSHCS benefits that are applicable to their circumstances at that time as well as other benefits that might address their needs. There shall also be evidence that the LHD contacts enrolled clients/families at least annually to provide updated information about the CSHCS program, benefits, assess family needs and update client information.

Documentation Required:

(The first four bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the process for the contact at initial enrollment (who, what and when) including but not limited to general CSHCS program information and a description of CSHCS benefits applicable to the current client/family circumstances, as well as other related programs/benefits.
- Written policy and procedure delineating the process for annual contact (who, what and when), which includes at a minimum, updated information about the CSHCS program, benefits, assessment of client/ family needs and collection of updated client/family information.
- Dated client chart notation or other documentation including staff identifier that the client/family has been informed of the various applicable CSHCS benefits initially and during the annual contact at a minimum.
- Dated client chart notation or other documentation including a staff identifier that the client/family has been contacted at least annually.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated plan of care documenting notification with staff identifier to client/family regarding program benefits and updated information received at least annually.
- Dated "Notice of Action" or other documentation to MDCH/CSHCS to share updated client/family information as needed.

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- On-site interview that indicates how the LHD makes the initial contact and the annual contact with families and how they inform of the required information.

Evaluation Questions:

- Has the LHD initiated contact with new clients/families?
- Has the LHD made contact with families on an annual basis at a minimum to share updated program information, assess client/family need and obtain updated client information?

Indicator 6.2

LHD CSHCS shall assist the CSHCS enrolled client/family with needs related to CSHCS care and services.

This indicator may be met by:

There shall be evidence that the LHD CSHCS assists enrolled clients/families with their needs related to care and services.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to enrolled clients/families addressing their care and services needs.
- Dated client chart notation documenting the client/family has been assisted with their needs related to care and services and staff identifier.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated notation in client's plan of care documenting the assistance the client/family has identified as needing with their care and services.
- Dated Notice of Action to MDCH/CSHCS requesting action that addresses the client's/family's needs related to care and services.
- Dated care coordination billing specific to assisting a client/family with their needs related to care and services.
- On-site interview that indicates how the LHD assists enrolled clients/families with their needs related to care and services.

Evaluation Question:

Does the LHD CSHCS program assist clients and families in regard to their care and service needs?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 6.3

LHD CSHCS shall facilitate transition through the Medicaid Health Plan (MHP) process and into the MHP environment for CSHCS/Medicaid clients prior to and if needed, up to six months after aging out of CSHCS following the CSHCS required procedures as outlined in the CSHCS Guidance Manual for Local Health Departments.

This indicator may be met by:

There shall be evidence that the LHD provides assistance to clients, who are aging-out of CSHCS and will become enrolled with a MHP after CSHCS coverage ends, in transitioning into the MHP environment in accordance with CSHCS published policy.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to CSHCS clients who are aging-out of CSHCS and enrolling/transitioning into an MHP.
- Dated client chart notation including staff identifier documenting the client has received assistance to enroll in and transition to an MHP following the CSHCS policy and procedure.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated care coordination billing.
- On-site interview that indicates how the LHD assists clients who are aging out of CSHCS and will go into a MHP.

Evaluation Question:

Does the LHD assist with the transition of clients who are aging-out of CSHCS and going into a MHP?

Indicator 6.4

LHD CSHCS program shall facilitate transition for CSHCS enrolled youth ages 18 and 20 and their families. When already in contact with CSHCS enrolled youth/families at earlier periods, the LHD CSHCS program shall begin the transition process as appropriate.

This indicator may be met by:

There shall be evidence that the LHD facilitates transition of youth ages 18 and 20 following the CSHCS guidelines. There shall be evidence that transition processes were begun prior to age 18 if the LHD was already in contact with the family.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to clients who are nearing identified transition ages.

- Dated client chart notation documenting the client has received assistance in preparing to transition into adulthood and staff identifier.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated notation in client's plan of care regarding the identified needs of the client/family with transition toward adulthood.
- Dated Notice of Action to MDCH/CSHCS requesting action that addresses the client's/family's needs related to transition to adulthood
- Dated care coordination billing specific to assisting a client/family with transition to adulthood.
- On-site interview that indicates how the LHD assists in the transition of youth ages 18 and 20 and of youth/family for those under age 18 that the LHD is already in contact at the appropriate times.

Evaluation Questions:

- Does the LHD assist with the transition of clients from youth toward adulthood at ages 18 and 20?
- Does the LHD CSHCS program assist with transition at transition periods earlier than age 18 when already in contact with the family?

Indicator 6.5

LHD CSHCS shall assist and authorize funded in-state travel assistance for CSHCS enrolled families as needed following CSHCS policies and procedures.

This indicator may be met by:

There shall be evidence that the LHD CSHCS is assisting and authorizing in-state travel following CSHCS published policy for CSHCS enrolled client/families as needed and guidance in the Guidance Manual.

Documentation Required:

(The first three bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to clients/families in need of in-state transportation.

- Written policy and procedure delineating how to authorize in-state transportation for clients/families in accordance with CSHCS published policy and Guidance Manual.

- Dated client chart notation documenting the client has received in-state transportation assistance and staff identifier.

Section XII: Children's Special Health Care Services (CSHCS)

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated notation in client's plan of care regarding in-state transportation assistance needs.
- Dated/signed CSHCS Transportation form (Form #MSA-0636) for specific clients.

Evaluation Question:

Does the LHD assist with and provide authorization for in-state transportation services for clients/families following CSHCS policies and procedures?

Indicator 6.6

LHD CSHCS shall assist with funded out-of-state care and out-of-state transportation for CSHCS-enrolled families as needed.

This indicator may be met by:

There shall be evidence that the LHD CSHCS is assisting clients/families as needed with out-of-state care and out-of-state transportation.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to clients/families in need of out-of-state care and out-of-state transportation.
- Dated client chart notation documenting the client has received out-of-state care and out-of-state transportation assistance and staff identifier.

Examples of further documentation needed that meet the requirement, including but not limited to.

- Dated and signed notation in client's plan of care regarding out-of-state care and out-of-state transportation needs/assistance.

Evaluation Question:

Does the LHD assist with out-of-state transportation services for clients/families as needed?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 6.7

The LHD CSHCS program shall provide Level I and Level II care coordination and make case management available to CSHCS families as needed, according to current CSHCS policies and procedures.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program is providing Level I and Level II care coordination services and making case management services available to clients/families as needed in accordance with current CSHCS policies and procedures.

Documentation Required:

- Written policy and procedure delineating how Level I and Level II care coordination services are provided to clients/families when needed.
- Written policy and procedure delineating how case management services are made available to clients/families when needed.
- Dated client chart notation documenting the client has received Level I or Level II care coordination services or case management services and staff identifier.
- Dated notation in client's plan of care indicating the client has received Level I or Level II care coordination services or case management and staff identifier.
- Dated, client-specific care coordination billing indicating Level I and/or Level II care coordination. Materials should be submitted in advance of the review.
- Dated, client-specific case management billing. Materials should be submitted in advance of the review.

Evaluation Questions:

- Does the LHD provide Level I and Level II care coordination to clients/families when needed following CSHCS policy and procedures?
- Does the LHD make case management available to clients/families appropriately?

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