Local Health Departments
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Introduction

Developed in direct consultation with the Program's participants, this Users' Guide is intended to systematically outline, clarify, and explain all relevant policies, procedures, and processes integral to successful participation in the Accreditation Program. This document is also interactive, meaning that text which appears in blue and is underlined may be followed to another destination in the document or on the Internet by holding down the CTRL key and then clicking on the text with a mouse.

This document is part of a continuous quality improvement process. It is fluid and fully expected to change as local public health departments provide input regarding points that contribute to its usefulness. To retain consistency regarding the application of responses, please contact one of the individuals below.

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Overview

History

The State of Michigan has a mature, organized, and institutionalized local public health accreditation program. The timeline begins with the establishment of the Public Health Code in 1978, followed by the state/local development of Minimum Program Requirements (MPRs) in 1980. During 1989, with state technical assistance, local health departments used the Assessment Protocol for Excellence in Public Health (APEX*PH*) tool as a means to assess and enhance the core capacities. During 1989 – 1992, Established Committees One and Two (comprising state/local public health leaders) recommended pursuing accreditation. These early collaborative efforts defined the attributes of a local health department and served as the basis for the Michigan Local Public Health Accreditation Program (MLPHAP).

The mission of this living program is to assure and enhance the quality of local public health in Michigan by identifying and promoting the implementation of public health standards for local public health departments and evaluating and accrediting local health departments on their ability to meet these standards. The Program's goals are to:

- Assist in continuous quality improvement;
- Assure a uniform set of standards that define public health;
- Assure a process by which the state can ensure local level capacity to address core functions;
- Provide a mechanism for accountability.

Governance

The governing authority for the MLPHAP is the Michigan Department of Health and Human Services (MDHHS). Three state agencies comprise the accrediting body:

- Michigan Department of Health and Human Services
- Michigan Department of Agriculture and Rural Development
- Michigan Department of Environmental Quality

An Accreditation Commission maintained by the Michigan Public Health Institute (MPHI) serves as the advisory body for Michigan's Accreditation Program.

Standards

The state health department is responsible for establishing minimum standards of scope, quality, and administration for the delivery of required and allowable services as set forth under the Public Health Code. The current model is based on Minimum Program Requirements (MPRs).

- MPRs are constructed through a formal process (Policy 8000).
- MPRs must be based in law, rule, department policy or accepted professional standards.

Process

The Accreditation Program assesses the ability of a local health department to meet minimum administrative capacity requirements. The Accreditation Program also conducts performance reviews for contractual local public health operations services and some categorical grant funded services provided by a local health department. The review process requires a team of approximately 50 state-agency reviewers, of which about 15 are used for each on-site review. The review cycle is 3 years.

There are three steps to the Accreditation process:

1. Self-Assessment
2. On-site Review
3. Corrective Plans of Action (CPA)

Following the on-site review, and CPA processes, there are three Accreditation status options. These are:

- Accredited
- Accredited with Commendation
- Not Accredited

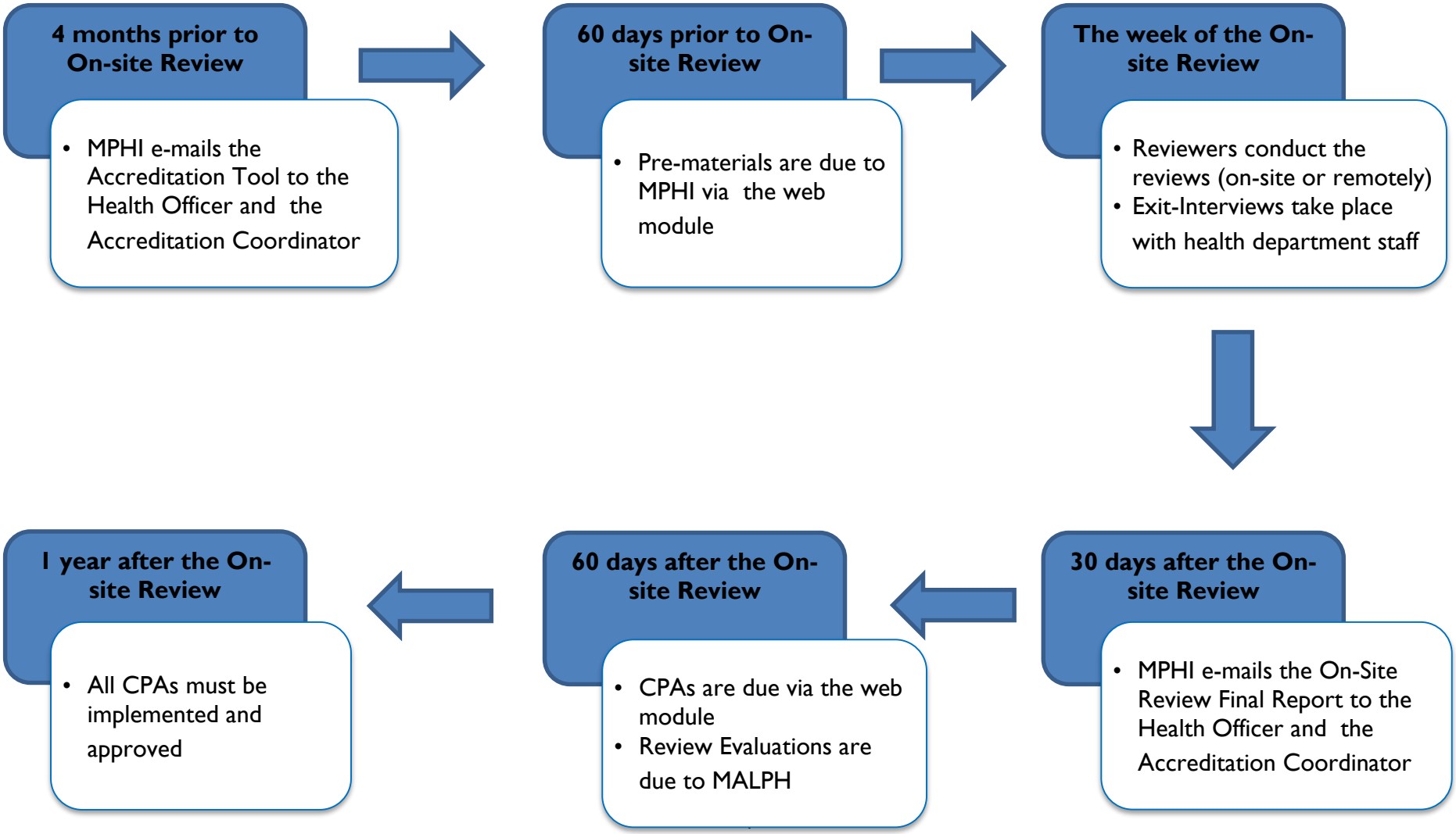
Evaluation

MPHI conducts regular evaluations of the Michigan Local Public Health Accreditation Program and its components at the conclusion of each 3-year cycle. Evaluation results and data are used to improve the quality of the program.

Conclusion

The work that has been undertaken in Michigan to achieve the goals of building capacity and infrastructure development began with the creation of the Public Health Code (Act 368 of 1978), specifically Section 24 which begins to define the role of local health departments in Michigan. Without this framework, Michigan would have been challenged to establish an Accreditation Program with the depth and breadth present today. Continued commitment and collaboration by the Michigan Departments of Health and Human Services, Agriculture and Rural Development, and Environmental Quality; the Michigan Public Health Institute; Michigan's 45 local public health departments; and the Michigan Association for Local Public Health will enhance Michigan's Accreditation Program, improve the quality of local programs and services, and shape the future of public health in Michigan.

The Michigan Local Public Health Accreditation Process



Self-Assessment
What to expect

The Self-Assessment is the first step in the Accreditation process. A local health department completes the self-assessment, which serves as an internal review of the department's ability to meet the minimum program requirements. The Self-Assessment phase begins four (4) months before the On-site Review, when MPHI sends the local health department's Health Officer an email with a link to the Tool and accompanying files that will aid in constructing a binder/print version of the Tool, if desired, which includes electronic files for divider tab labels, a cover, and a spine. The email also highlights pertinent dates in the process as they apply to the each health department. The Tool is located on the Michigan Local Public Health Accreditation Program website: https://accreditation.localhealth.net/accreditation-tools-timeline/.

The Self-Assessment should be completed using the MPR Indicator Guide for each section on which the local health department will be reviewed. The MPR Indicator Guide presents detailed information on the documentation a local health department provides in order to fully meet the indicators.

In order to facilitate the flow of information between the local health department and MPHI during all phases of the process, the local health department should appoint an Accreditation Coordinator and identify that person to MPHI on the Profile Information **area of the Web Module and the Module User Account Request form** when pre-materials are submitted via the Web Module. Unless otherwise notified, MPHI will consider this person the single point of contact during the process.

Next steps

There are several important pieces that need to be completed by the local health department and delivered to MPHI to officially complete the Self-Assessment phase. **All materials will be submitted via the Web-based Reporting Module.**

On-site Review Schedule: Due to MPHI 2 months prior to the On-site Review.

The local health department will create the schedule for the 5-day review while adhering to the **Scheduling Guidelines provided in Appendix I**. It is understood that staff members will often be responsible for multiple programs. This and other factors should be taken into consideration as the schedule is being prepared. MPHI and the Accreditation reviewers will receive the local health department's schedule as final. In the event that either a reviewer or the local health department need to make changes to this schedule after it is submitted to MPHI due to extenuating circumstances or unforeseen events, it is critical that MPHI be contacted as soon as it is evident that a change to the schedule is needed. MPHI will then coordinate the process to arrive at a revision that is mutually acceptable.

Within two weeks of submission, MPHI will email the Health Officer or appointed Accreditation Coordinator to notify them that their schedule, modified to include reviewer contact information, is available to view on the web-based reporting module. This schedule will identify the reviewer responsible

for each section and that individual's phone number and email address to assist in pre-review communication.

The three-year On-site Review calendar has been established well in advance. Due to the complex nature of the Accreditation cycle, changes to the review dates will not be customarily considered. However, in unusual instances the local health department may request a schedule change.

If a local health department needs to reschedule its On-site Review, they must request a scheduling change, in writing, at least three months prior to the start of the scheduled Self-Assessment period. The request must be mailed to MPHI and include the rationale for the schedule change. MPHI will collaborate with MDHHS, MDARD, and MDEQ regarding the feasibility of accommodating the request. All parties will be notified of the outcome.

Requested Pre-materials: Family Planning and Children's Special Health Care Services

Some services/programs administered by a local health department produce extensive protocols. To that end, the Family Planning program has requested that protocol manuals and other relevant information be submitted in advance of the review to ensure accuracy and expediency of the review.

The Children's Special Health Care Services Program has requested that policy and procedure manuals and other relevant information be submitted in advance of the review to ensure accuracy and expediency of the review. **Items required and forms may be found in Appendix I**.

Family Planning Pre-materials:

All Family Planning pre-materials **(see page 83 for details)** should be sent directly to the Family Planning program:

Electronic Submission: Judy Stiles (stilesj@michigan.gov) or Barbara Derman (dermanb@michigan.gov)

Or hard copy materials can be mailed to:
Judy Stiles
Women's Health Unit
Michigan Department of Community Health
109 W. Michigan Ave., 3rd Floor
Lansing, MI 48913

Children's Special Health Care Services Pre-materials:

All Children's Special Health Care Services (CSHCS) pre-materials should be sent directly to the CSHCS program using the secure electronic method of communication designated by CSHCS (currently known as EZ-Link). You will be contacted by CSHCS before your scheduled visit with specific information for submission.

Technical Assistance:

Local health departments should contact relevant state agency staff in the event that clarification is needed regarding minimum program requirements and/or indicators**. A list of state agency staff is provided in Appendix I** that includes names, email addresses, and phone numbers.

Submission to MPHI:

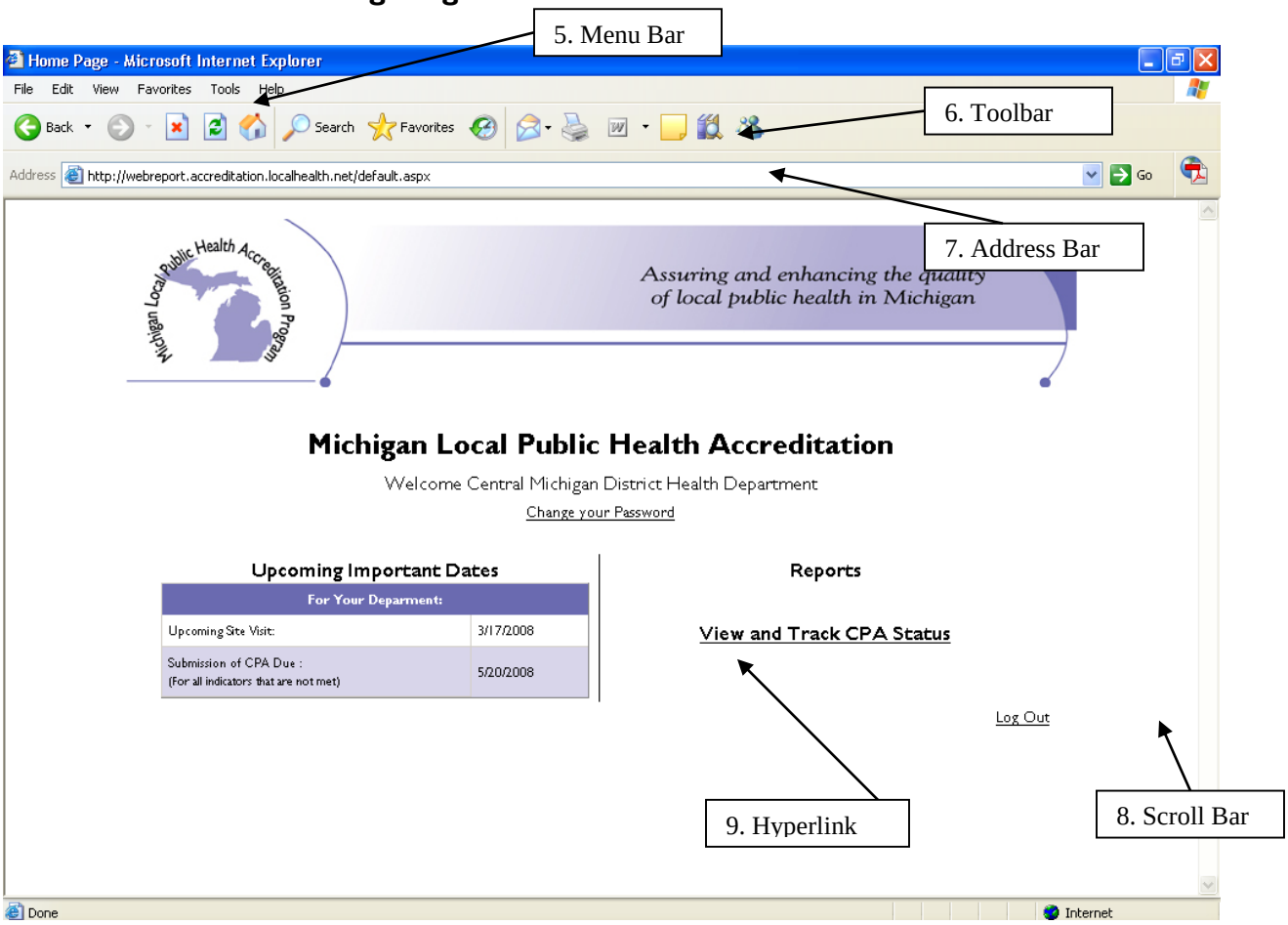
The following items should be submitted via the web-based reporting module **2 months prior to the On-site Review:**

- ☐ On-site Review Schedule
- ☐ Exit Conference Request Form
- ☐ Profile Information Form

Tips to facilitate the process:

- Be certain to allow enough time for the Self-Assessment phase by beginning upon receipt of your Accreditation Tool.
- Assemble a management team comprising the Health Officer, Medical Director, Finance Director, Personal Health Services Director, and the Environmental Health Director (or equivalents). Remember to include the designated Accreditation Coordinator if not already represented above. Regular meetings for progress reports are beneficial.
- Keep all staff and other relevant entities informed about the Accreditation process, including the local governing entity (Board of Health, County Commission, etc.).
- Fresh eyes looking at programs in the local health department can often make a positive impact in preparation. Utilize and involve your staff by having them review programs other than their own. For example, the immunization staff could review the food service sanitation program; the food service sanitation program could review the immunization program and so on.

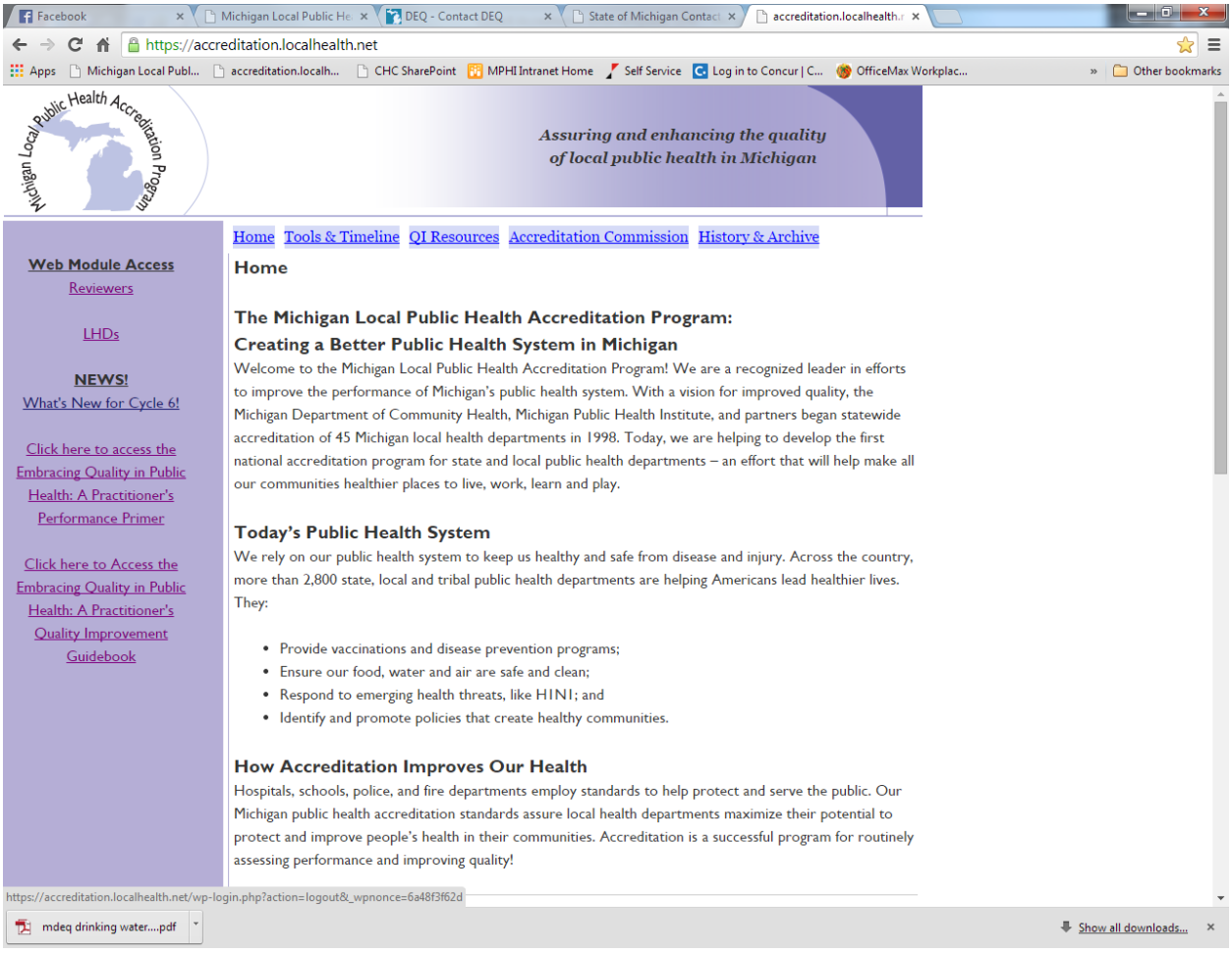
Navigating the Accreditation Web Module



Accessing the Website

Open your Internet browser (this user manual will assume that you are using Microsoft Internet Explorer 8.0 or higher), and type: https://accreditation.localhealth.net/ into the address bar of the browser.

On the left side of the screen, there is a purple bar. Click on the "LHDs" link. On the Local Health Department Pre- and Post-Review Tools page, click on the "Cycle 6 Web-based Reporting Module" link.



You may want to create a bookmark for this website so that you can easily access it in the future without having to remember the text you would need to type in the address bar. Follow your browser's directions to add the website to your favorites.

Logging in to the Web-module

A form to request web-module user accounts is sent with your local health department's tool letter. Please submit this form by email to Jessie Jones at jjones@mphi.org **no later than 2 weeks prior to your pre-material's due date.** MPHI will create user accounts for each person listed on the form when it is submitted. The first time you log in to the web-module you will be asked to set a password.

Health Officers' accounts have special permissions that allow them to sign-off on and submit the local health department's Corrective Plans of Action. All other accounts will have standard local health department access to the web-module.

Important! We must request that you absolutely refrain from using your browser's "Back" button to navigate within the module. Because of the dynamic nature of web programming, the system does not function as ordinary websites do. Using the "Back" button at any time instead of using the navigational links provided within the module can cause multiple issues with reading or printing your reports. In short, **never use the "Back" button; always use the navigational links that are liberally distributed throughout the module.**

Changing Your Password

Should you forget your password, you can click the "forgot password" link on the sign-in page of the web-module to reset your password. If you have any issues logging into the web-module, please contact Jessie Jones at jjones@mphi.org or (517) 324-8387.

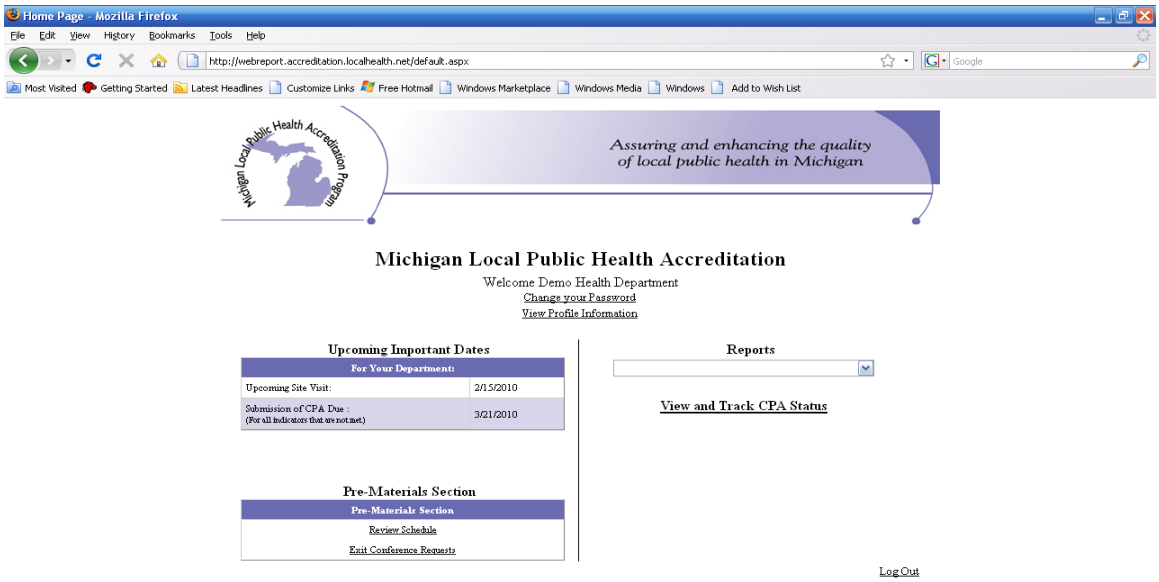
To change your password:

1) Click on the "Forgot your password" hyperlink located on the module log in page. This will take you to the Change Password page.
2) Enter your user name and click on the "Reset Password" button. The system will send an email to you that will contain a password reset link.
3) Follow the directions in the email to reset your password.


Assuring and enhancing the quality of local public health in Michigan
Michigan Local Public Health Accreditation
Change Your Password
Changing password for: Demo User (demo)
Old Password:
New Password:
Repeat New Password:
Change Your Password!

Local Health Department Home Page

Upon login, you will be taken to your local health department's home page. On the left side of the page, you will see a list of upcoming important dates and reminders as well as access links for pre-materials.

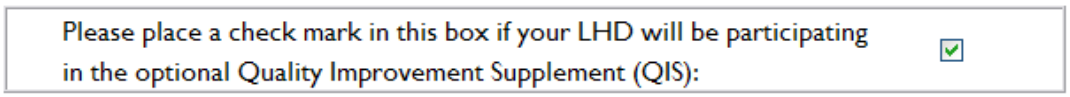


Pre-materials

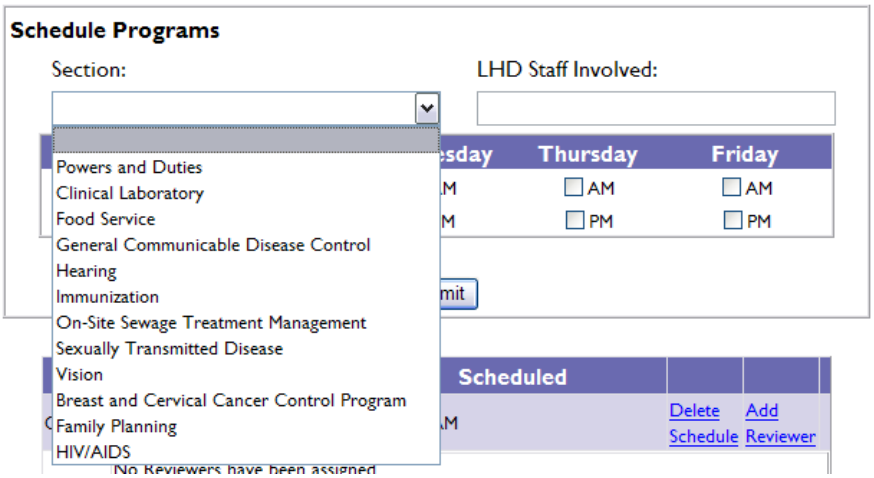
All local health department pre-materials are submitted via the web-module, including the on-site review schedule and exit conference requests. Some programs require materials be sent in advance of the on-site review. Please see pages 45 through 102 for further information.

To enter your schedule, click on Review Schedule on the bottom left side of the screen. You will be taken to a screen that looks like this:

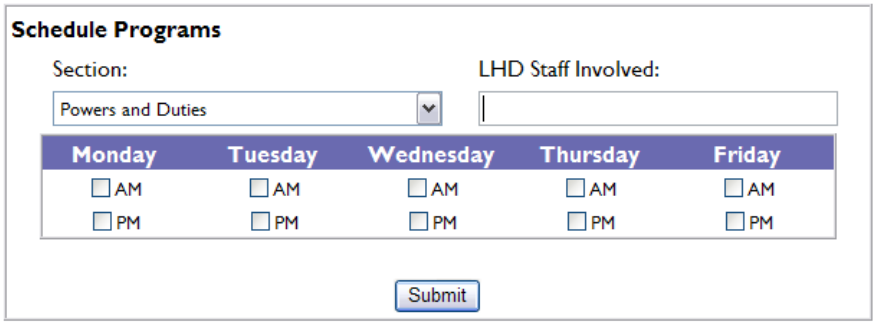
First, place a checkmark in the box on top of the page if your local health department will be participating in the optional Quality Improvement Supplement (QIS).



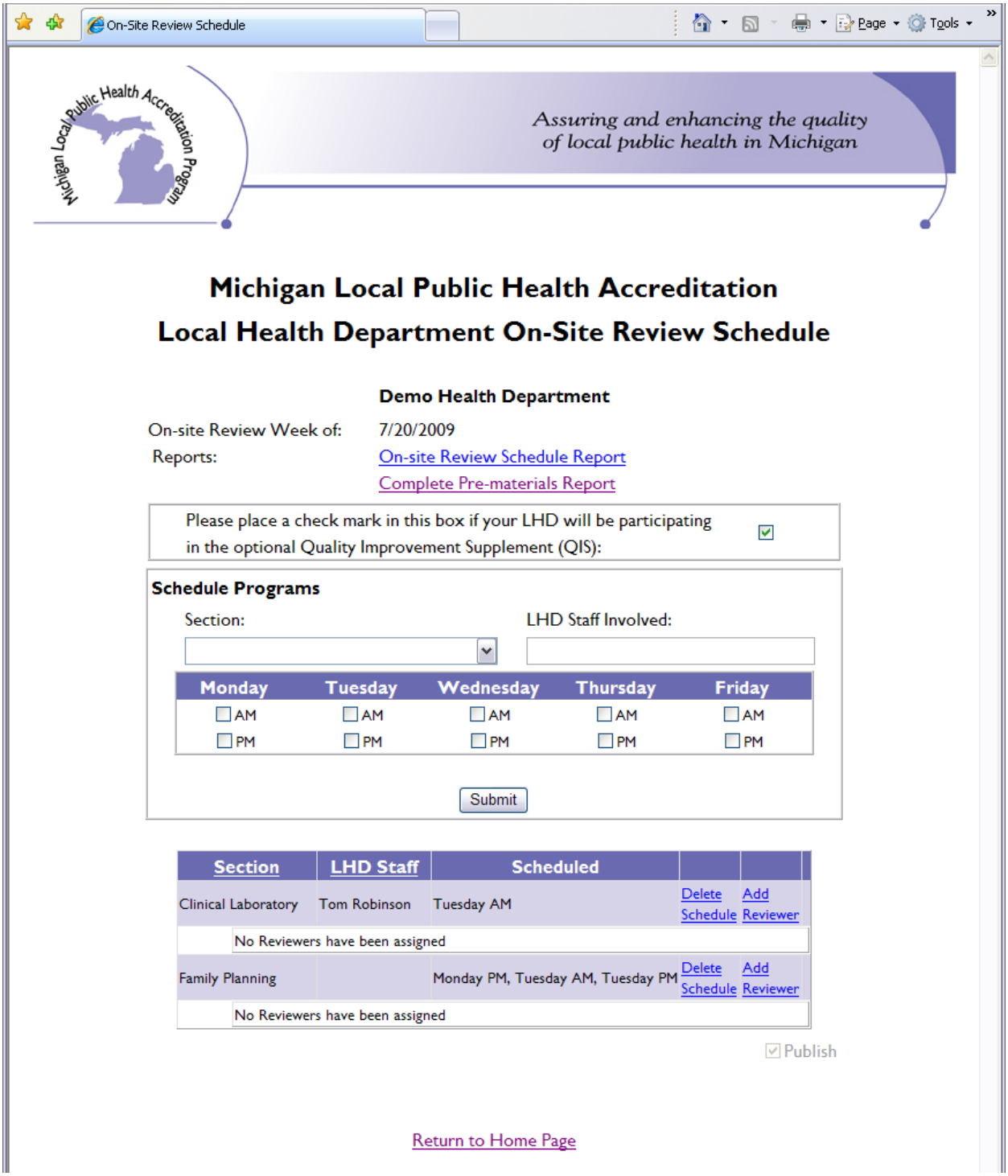
To schedule a program, choose the section you wish to schedule from the drop down box on the far left.



Once the program is selected, click in the box under "LHD Staff Involved" and enter names of the local health department staff who will be participating in the review. Then, choose the timeslots the program is to be scheduled (e.g., Monday AM, Friday PM, etc.) by checking the appropriate boxes. Refer to page 43 and 44 for scheduling guidance.



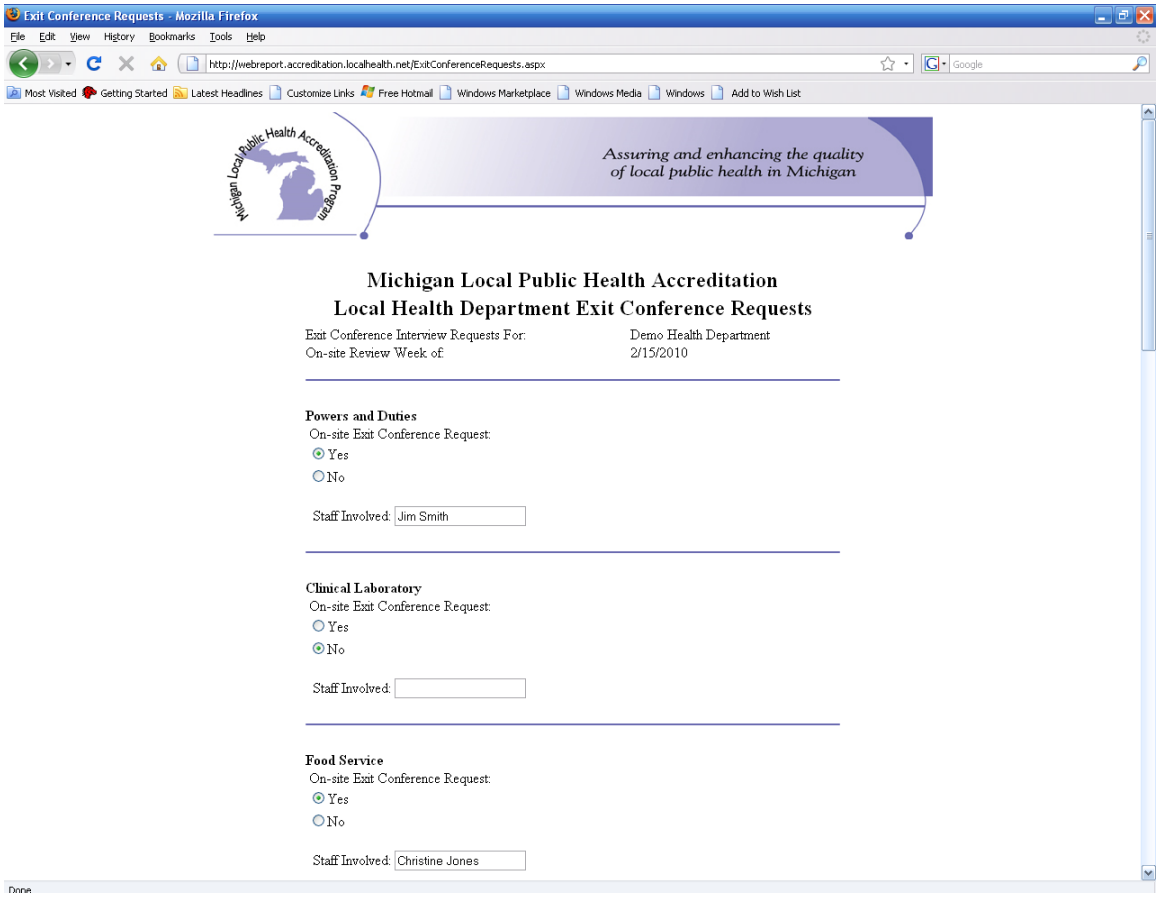
After you have made your selections, click on "Submit" and the program will add it to the schedule. A purple and white table will display at the bottom of the page as schedules are added.



If you make a mistake in scheduling, you may click on "Delete Schedule" to remove the entry from the schedule.

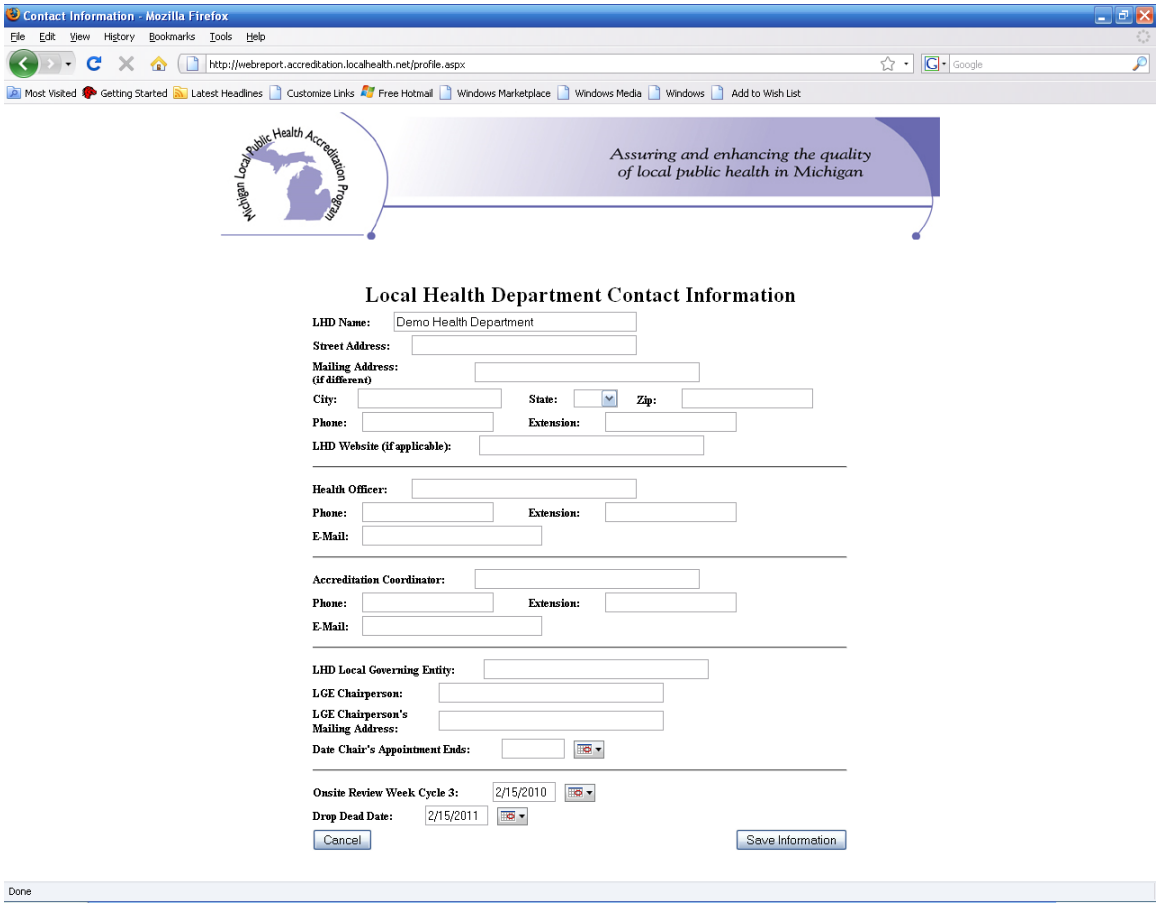
To enter your exit conference requests, return to the local health department home page and click on "Exit Conference Requests" on the bottom left side of the page.

For each program, choose "Yes" or "No" to indicate if you would like an exit conference and enter the names of staff members who will participate in the exit conference.



When you have <u>finished</u> entering your exit conference requests for all programs, click "Save" on the bottom of the page. Please note, once you clicked "Save" you will be unable to make further changes to this form. *If further changes are required, please contact Jessie Jones at jjones@mphi.org or (517) 324-8387.*

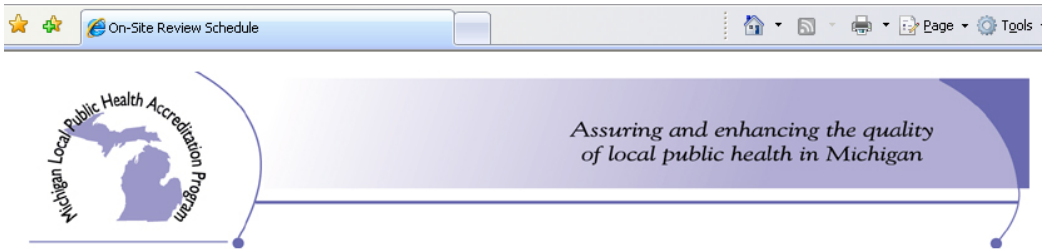
To edit your local health department's contact information, click on "View Profile Information" at the top of the local health department home page. On the bottom of the contact information page, click on "Edit this Information." You will be taken to a screen that looks like this:



Once you have entered your local health department's current contact information, click on "Save Information."

The most crucial piece of information to capture accurately is the Accreditation Coordinator's e-mail address, as this person will be receiving auto-generated e-mails from the website related to Corrective Plans of Action responses.

Once you have finished entering your pre-materials, MPHI staff will review them for accuracy of scheduling and contact you with any questions. MPHI staff will also add reviewer names and contact information to the schedule and notify you once it is available for viewing. You may review your schedule by returning to the local health department home page and clicking again on "Review Schedule." You will be taken to a page that looks like this:



Michigan Local Public Health Accreditation
Local Health Department On-Site Review Schedule

Demo Health Department

On-site Review Week of: 7/20/2009
Reports: On-site Review Schedule Report
Complete Pre-materials Report

Please place a check mark in this box if your LHD will be participating in the optional Quality Improvement Supplement (QIS): ☑

Schedule Programs

Section: LHD Staff Involved:

Monday	Tuesday	Wednesday	Thursday	Friday
☐ AM	☐ AM	☐ AM	☐ AM	☐ AM
☐ PM	☐ PM	☐ PM	☐ PM	☐ PM

Submit

Section	LHD Staff	Scheduled		
Clinical Laboratory	Tom Robinson	Tuesday AM	Delete Schedule	Add Reviewer
No Reviewers have been assigned				
Family Planning		Monday PM, Tuesday AM, Tuesday PM	Delete Schedule	Add Reviewer

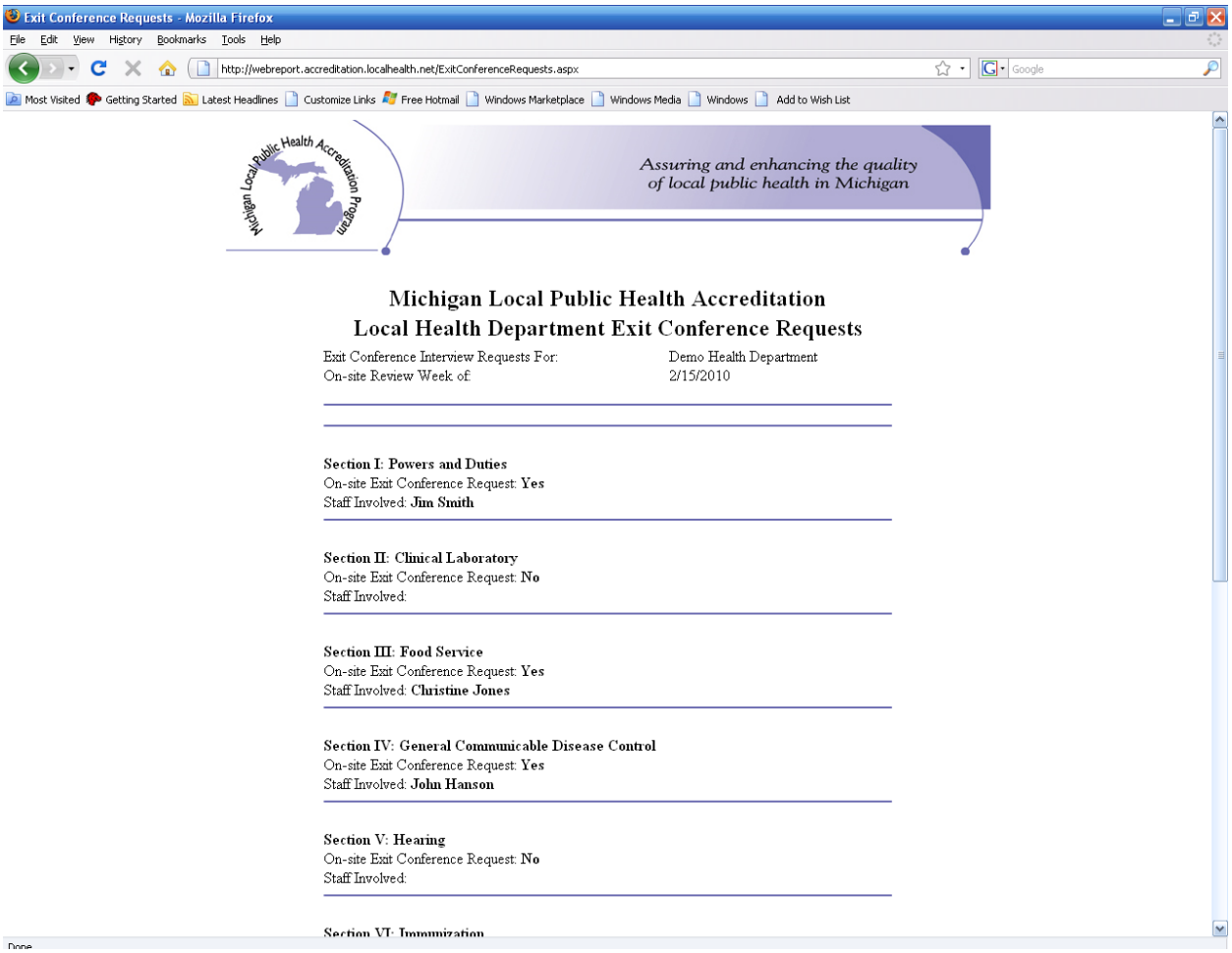
Reviewer Name	Phone	Email	
Barbara Coy	517-335-4604	coyb9@michigan.gov	Remove
Liz Harton	517-335-8333	hartone@michigan.gov	Remove
E.J. Siegl	517-335-8814	sieglej@michigan.gov	Remove

☑ Publish

Return to Home Page

The purple and white table in the center of the page lists the reviewers' contact information and timeslots for each program.

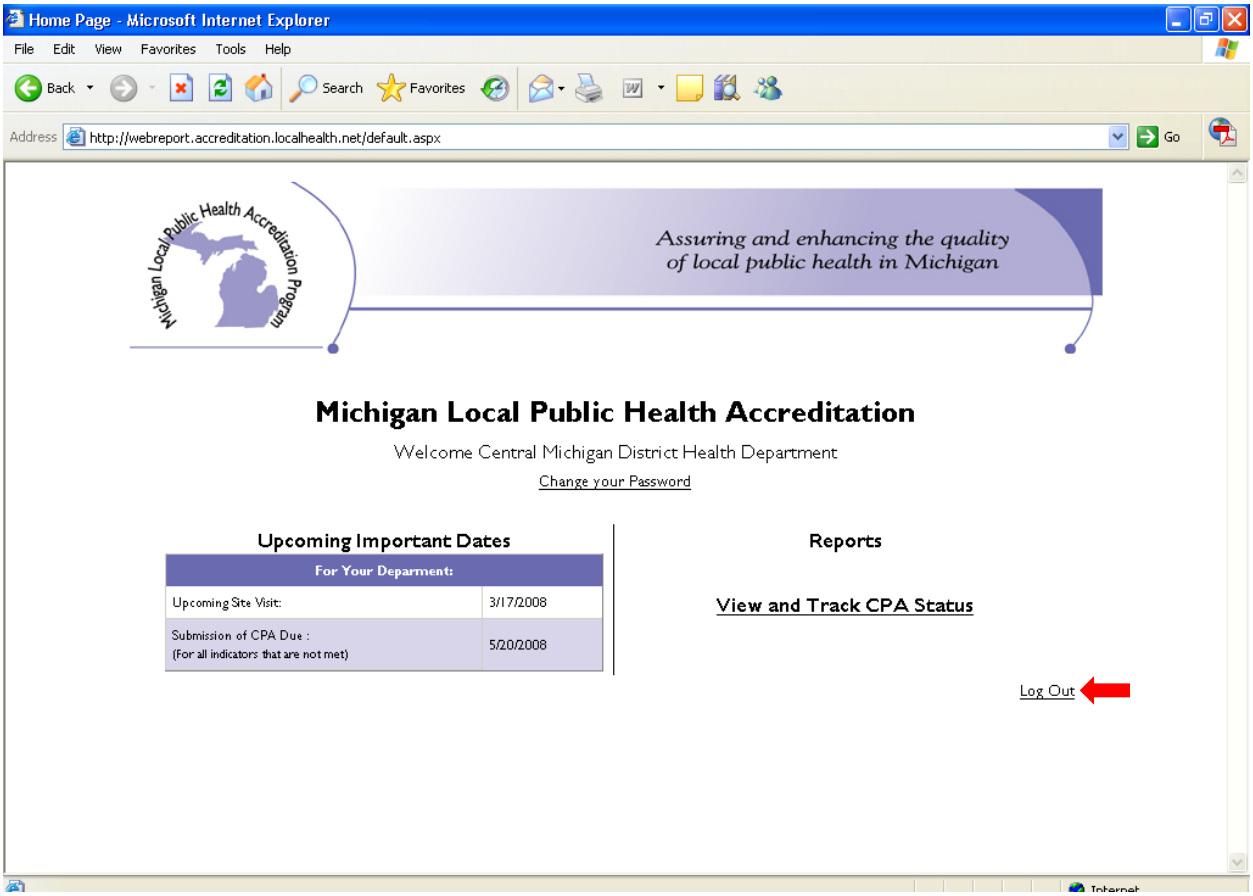
If you click on Exit Conference Requests on the local health department home page, you will be taken to a screen that looks like this:



If you wish to access your pre-materials all at once, including schedule, exit conference requests, and contact information, once you are in the review schedule screen, click on "Complete Pre-materials Report." If you wish to access a PDF of the schedule only, click on "On-site Review Schedule Report."

Exiting the Web-module

Important! A "Log Out" hyperlink is located at the bottom of the main local health department home page. We ask that you use this hyperlink to exit the web-module before closing your Internet browser. The reason for this again has to do with the nature of Web programming. When you simply close your Internet browser, the website cannot detect this type of exit and thinks that you are still logged in.


Home Page - Microsoft Internet Explorer
File Edit View Favorites Tools Help
Back Search Favorites
Address http://webreport.accreditation.localhealth.net/default.aspx
Go
Assuring and enhancing the quality of local public health in Michigan
Michigan Local Public Health Accreditation
Welcome Central Michigan District Health Department
Change your Password
Upcoming Important Dates
For Your Deparment:
Upcoming Site Visit: 3/17/2008
Submission of CPA Due : (For all indicators that are not met) 5/20/2008
Reports
View and Track CPA Status
Log Out

On-Site Review
What to Expect

Every local health department's experience with the On-site Review will be different, but if the local health department takes full advantage of all resources available to them during the Self-Assessment phase, the week-long review should progress smoothly.

Suggestions

- Spend your Self-Assessment period (and beyond) asking questions. Ask the state agency reviewers. Ask the technical assistance contacts. Ask MPHI. The more your local health department knows about the entire process, the better your On-site Review experience.
- Providing food and/or beverages for reviewers during the On-site Review is neither mandatory nor expected.
- Ensure the reviewers meet with the local health department staff identified on the schedule. If the scheduled staff member becomes unavailable at the last moment, let either the reviewer or MPHI know.
- Opening sessions on the first day of the week are not mandatory. Upon state agency reviewer arrival, engage them in dialogue that will determine logistics during the On-site Review, such as if local health department staff will be needed, what documentation may be required, etc.

Exit Conferences

If the local health department would like assistance in facilitating opportunities for program-specific exit conferences with state agency reviewers, the following should be submitted with the other pre-materials using the web-based reporting module:

1) Identify accreditation sections for which an exit conference is requested, and
2) Identify, by name, local health department representatives to be included in the conference (e.g., Health Officer, Program Director, etc.). Local health department preferences will be communicated to state agency reviewers before the On-site Review.

The On-site Review Report

Within 30 days from the last day of the week-long review, notification of the On-site Review Report's (OSRR) completion and access instructions are sent to the local health department (the Health Officer and/or the Accreditation Coordinator) and the local health department's local governing entity chairperson.

Indicator Designations

Four designations may be utilized by reviewers in evaluating indicators of the minimum program requirements (MPRs) for a given section:

- Met
- Not Met

- Met with Conditions
- Not Applicable

MET Designation
Indicators that are marked "Met" meet all of the necessary requirements as described in the guidance document.

NOT MET Designation
Indicators that are marked "Not Met" do not fully meet all of the requirements as described in the guidance document. Local health departments that do not fully meet all requirements for a specific indicator must develop and submit a corrective plan of action (CPA) specifying actions to be developed and implemented in order to achieve the requirements for this indicator. If an indicator is not met, the reviewer(s) are responsible for clearly and effectively communicating why the indicator is not met, providing a clearly articulated statement for the "Reason Not Met" field..

Once the health department enters their CPA into the web module, and the reviewer has evaluated the submitted information, the local health department will be notified if the plan of action is:

- Accepted, no further action required,
- Accepted with further action required, or
- Not accepted and will need to be resubmitted,

If further action is required, the type of action required will be dependent on the section and, state agency involved, and will be communicated to that local health department. (The state agency may conduct a follow-up review to verify implementation of the plan.)

More information on the CPA process can be found on page 32.

NOT APPLICABLE Designation
The "Not Applicable" status is used when an indicator is not applicable to a local health department, e.g., they do not participate in a component of the program being reviewed.

Please note: Important indicators should be marked only "Met" or "Not Applicable." They may not be assessed as "Not Met" or "Met with Conditions".

MET WITH CONDITIONS Designation
Each program has the option of awarding a "Met with Conditions" designation for an indicator reviewed during the accreditation process. This designation serves as an alternative to giving a Not Met when a minor, non-critical deviation is discovered in a review that does not warrant the preparation of a formal CPA. An explanation for the decision to mark an indicator "Met with Conditions", will be included under the heading "Met with Conditions" on the Accreditation report.

The follow-up for each indicator given a Met with Conditions will occur at the next cycle review. If the indicator remains unmet by the next cycle review, it will be marked "Not Met". However, at reviewer discretion, a Met with Conditions may be given on consecutive reviews when:

- An MPR/indicator has multiple elements
- The originally cited issue(s) has been corrected, and
- A different issue now results in a "Met with Conditions" rating

Due to the variation among the sections, state agencies conducting the reviews, and varying program requirements, it is the responsibility of each program to clearly describe in their guidance document the criteria that will be used for designating an indicator "Met with Conditions".

PROGRAM SPECIFIC MET WITH CONDITIONS LANGUAGE

LOCAL HEALTH DEPARTMENT POWERS & DUTIES

A designation of "Met with Conditions" for an indicator within the Local Health Department Powers and Duties Section (Section I) may be used at the discretion of the reviewer in cases where minor deviations exist. Any indicator marked "Met with Conditions" will be addressed during the Exit Conference and in the On-site Review Report. Recommendations for improvement will be offered and must be implemented before the next accreditation cycle to prevent the subsequent designation of "Not Met."

FOOD SERVICE PROGRAM

A Met with Conditions may be granted if the department overall meets the minimum program requirements, but occasionally minor deviations or clerical problems might indicate that the requirement is not met. Based on the requirements specified in the guidance document, a Met with Conditions may be given with the understanding that this MPR will be required to be met at the next scheduled evaluation. Failure to meet this indicator would result in a Not Met.

GENERAL COMMUNICABLE DISEASE CONTROL

A designation of "Met with Conditions" for an indicator within the General Communicable Disease Control Section will be used at the discretion of the reviewer and based upon importance of the deviation. When multiple components are needed to fulfill an indicator and the deviation is determined to be a non-critical issue by the reviewer (i.e., will not affect daily operations, investigations, or reporting of the LHD), the indicator will be marked as "Met with Conditions" and recommendations for improvement will be offered. Corrections to the indicator will need to be made before the next cycle to avoid being marked "Not Met".

HEARING & VISION

A designation of "Met with Conditions" for an indicator within the Hearing and Vision Screening Programs may be used at the discretion of the reviewer in cases where minor deviations that can be immediately addressed exist. This will be discussed at the exit interview and the Local Health Department agrees that their current protocol may be changed immediately to reflect the written indicator. The change in protocol will be confirmed at the next accreditation On-site Review.

IMMUNIZATION

A designation of "Met with Conditions" for an indicator within the Immunization Section may be used at the discretion of a joint consensus between the technical manager and the reviewer in cases where minor deviations exist. All of the indicators under the individual Minimum Program Requirements in the Immunization Accreditation tool are associated with program requirements outlined in the Omnibus Reconciliation Act of 1993, section 1928 and Part IV- Immunizations, Sec. 13631, as well as requirements in the 2007 Vaccines for Children (VFC) Operations Guide; Immunization Program Operations Manual (IPOM, 2013-2017) and Michigan's Resource Book for VFC Providers.

Indicators must be met in order for the program to be in compliance with the state and federal program requirements. Because some indicators require that report submissions are documented on designated

dates, it is difficult to base compliance on a 90 consecutive days timeframe. In those cases, a "Met with Conditions" mark would apply until the next date for compliance arrives. At this point the LHD is expected to submit timely reports, or the indicator will result in a Not Met.

ONSITE WASTEWATER TREATMENT MANAGEMENT

The appropriateness and basis for granting of "Met with Conditions" will be communicated for each indicator in the guidance document. Where a "Met with Conditions" rating is awarded, the specific conditions required to be met at the next scheduled evaluation will be clearly communicated in the Accreditation report. Where specific conditions have not been satisfied at the time of the next review, a "Not Met" rating will result.

SEXUALLY TRANSMITTED DISEASE and HIV/AIDS

A designation of "Met with Conditions" for an indicator within the Sexually Transmitted Disease and HIV/AIDS programs will be used at the discretion of the Accreditation reviewer on-site and based upon the significance of the deviation.

When multiple components are needed to fulfill an indicator and the deviation is determined to be a non-critical issue by the reviewer (i.e., will not affect daily operations, investigations, reporting of the local health department, or does not violate state law), the indicator may be marked as "Met with Conditions." When a "Met with Conditions" mark is being considered, it will be discussed with the accreditation reviewer's management prior to making this determination."

The reviewer will state the rationale for this designation in the accreditation report and recommendations for improvement will be clearly stated verbally and in the report. Any further action that is required will occur outside the Accreditation process and in conjunction with recurring quality improvement and program monitoring activities conducted by the state STD and HIV/AIDS programs. Corrections to the indicator will need to be demonstrated during the on-site review or scheduled within four weeks after the on-site review to avoid being marked "Not Met" or becoming a "Corrective Plan of Action."

BREAST AND CERVICAL CANCER CONTROL NAVIGATION PROGRAM (BCCCNP)

Several indicators under individual Minimum Program Requirements are linked as part of the overall program evaluation, but due to the complexity of these indicators, they are evaluated separately. Ongoing quality monitoring of these indicators occurs on a yearly basis and are officially reviewed every three years as part of the Accreditation process. Agencies that do not meet indicator requirements (as outlined in the guidance document) but demonstrate development and/or implementation of a process/procedure to meet the indicator requirements will be marked "Met with Conditions." The BCCCNP reviewer will state the rationale for designating this indicator "Met with Conditions" in the Accreditation report. Any further action that is required will occur outside the Accreditation process and in conjunction with recurring quality improvement and program monitoring activities conducted by the state BCCCNP program.

FAMILY PLANNING PROGRAM

All of the indicators under the individual Minimum Program Requirements in the Family Planning accreditation tool are linked to program requirements as they appear in the Federal and State Title X Program Requirements (42 CFR Part 59, Subpart A). Family Planning Program reviewers do not have the option of using a "Met with Conditions" designation, which would not assure correction of the failed requirement until the next review cycle (or an additional three years). Title X Guidelines require that programs are reviewed every three years for compliance with the guidelines.

WOMEN, INFANTS, AND CHILDREN (WIC)

A designation of "Met with Conditions" is not applicable for the WIC program.

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS)

A designation of "Met with Conditions" for an indicator within the CSHCS program will be used at the discretion of the reviewer on-site and based upon the importance of the deviation. When multiple components are needed to fulfill an indicator and the deviation is determined to be a non-critical issue by the reviewer (i.e., will not affect daily operations, investigations, or reporting of the LHD), the indicator will be marked as "Met with Conditions" and recommendations for improvement will be offered. Corrections to the indicator will need to be demonstrated during the On-site Review at the next cycle to avoid being marked "Not Met".

Reports
Accessing the Local Health Department On-site Review Report

The online Accreditation system generates several reports following the On-Site Review. In order to access these reports, log in to the website and select the Program Area from the drop down box under Reports. You will be given a list of options for which report you wish to access.

On-Site Review Report
Numeric summary of all sections

Sectional Status Report
Detailed report with comments for current section

Section Summary
Numeric summary of current section

Total Site Visit Report
Full detail of entire Accreditation Site Visit

View and Track CPA Status

Clicking on the "On-Site Review Report" will generate a printable PDF containing a grid with totals for all Met, Not Met, and Not Applicable indicators for all sections.

Clicking on the "Unpublished CPA Report" link will generate a list of CPAs that your local health department has not yet submitted for approval.

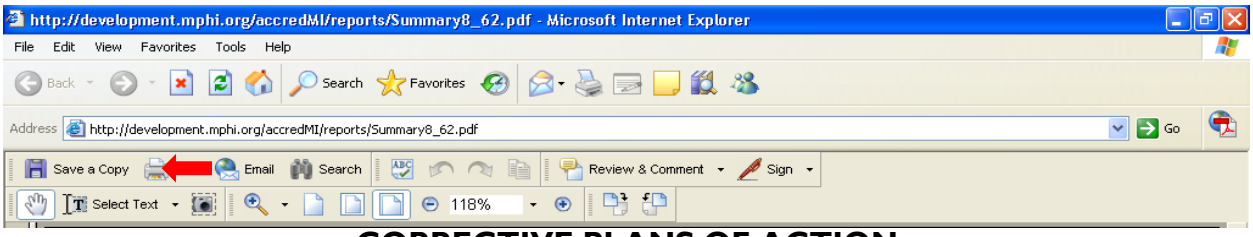
Clicking on the "Sectional Status Report" link will generate a printable PDF of the On-site Review Report for the section currently being viewed, which includes Met, Not Met or Not Applicable data for each indicator as well as any reviewer comments.

Clicking on the "Section Summary Report" will generate a printable PDF containing a grid with totals for all Met, Not Met, and Not Applicable indicators which have been entered for the section currently being viewed.

Clicking on the "Total Site Visit Report" link will generate a PDF of your local health department's entire site visit report (all sections).

Printing Reports

To print a PDF file, click on the "Print" button on the upper left side of the screen (your version of Acrobat Reader may vary). This will open a print dialog box where you can choose your printer and printer options.



CORRECTIVE PLANS OF ACTION
What to expect

The Corrective Plan of Action (CPA) process provides a mechanism for program or service improvement. The plan estimates implementation time and designates a local health department contact.

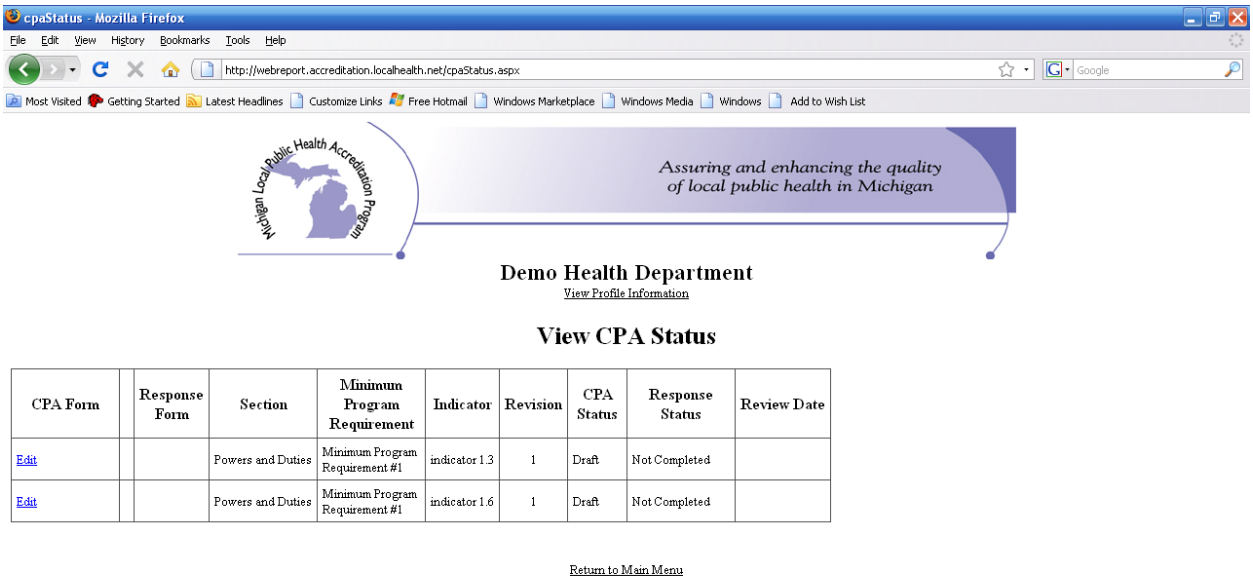
Local health departments that do not fully meet all essential requirements must develop CPAs for missed indicators. When preparing CPAs, local health departments should use the Corrective Plan of Action form located on the Web-based Reporting Module. A **copy of this form** (for reference only) can be found in Appendix IV.

The timeline for CPA implementation begins at the conclusion of the On-site Review. CPAs must be entered into the web module within 60 days of the end of the On-site Review. As a result of exit conferences, local health departments should be aware of missed indicators and can begin developing their CPA(s).

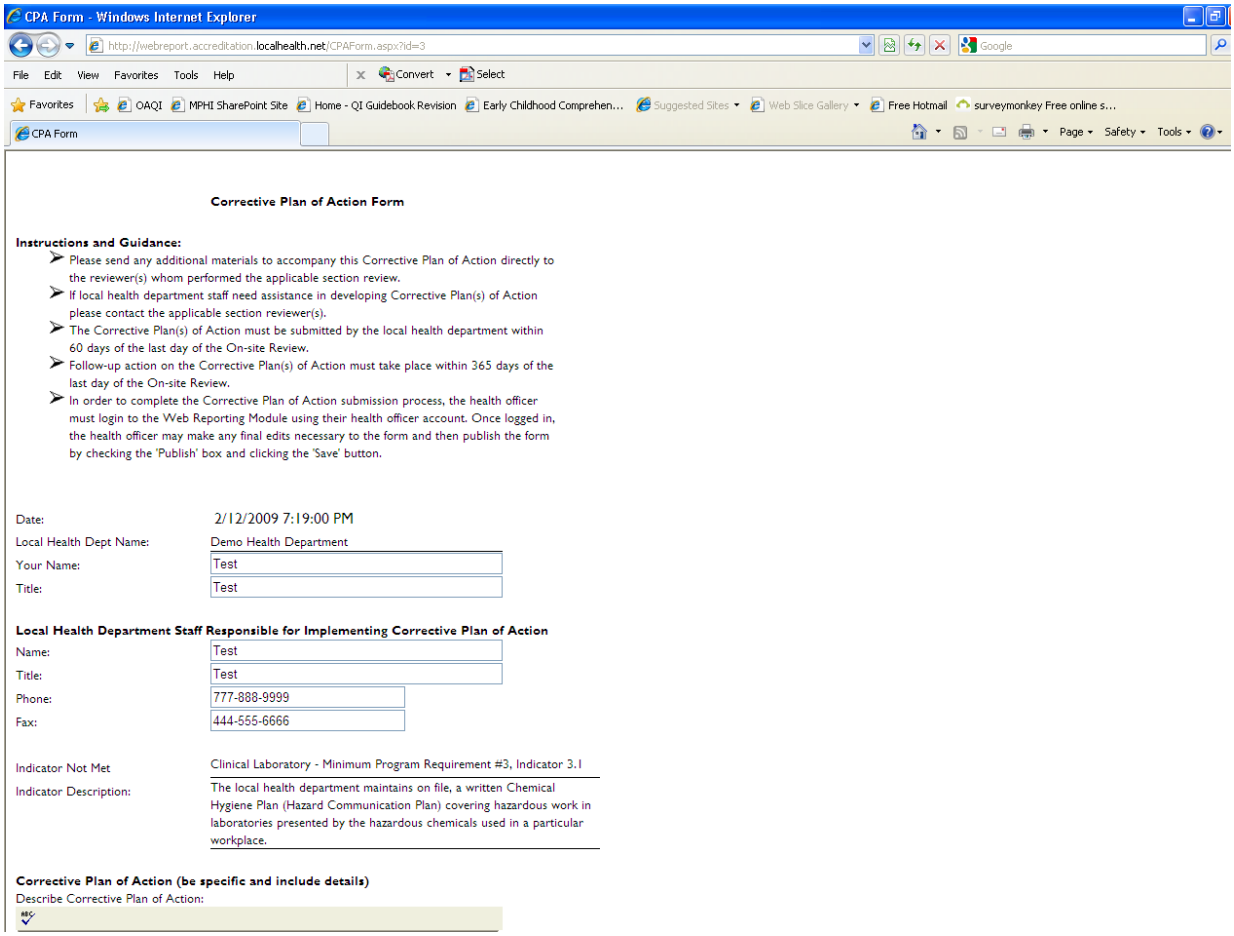
What to do

1. Each indicator designated "Not Met" will require its own individual CPA form.
2. Develop the plan with input from staff.
3. Contact the reviewer responsible for your review or state agency technical assistance staff for the unmet indicator(s) as you develop your plan(s).
4. Submit the plans online through the web-based reporting module. **Submission of the CPA will require your Health Officer's unique username and password, thus ensuring the Health Officer's opportunity to 'sign off' on the CPA.**
5. If you have additional materials that must accompany your CPA, please send them either via e-mail or hard copy to your applicable section reviewer(s).

To submit CPAs, click on the "View and Track CPA Status" link from the local health department home page. You will be taken to a table that looks like this:



To edit your local health department's CPA response form, click "Edit" next to the indicator for which you are entering a CPA.



Next steps

MPHI will log the receipt of each plan and email the appropriate state agency reviewer(s) within 48 hours of receipt. **The state agency reviewer(s) has 30 days from the local health department's submission date** to MPHI to respond to the plan(s). The options for this response are as follows:

- Yes, with no further action required- This response is used when the local health department has proven compliance simply by CPA submission. This completes the CPA cycle for that indicator.
- Yes, with further action required- This response is used when the reviewer requires either a site revisit or materials from the local health department. If materials are required, you will see a date by which they should be sent to the reviewer/program area. If your local health department requires a site revisit, you will see a date by which the site visit must be completed. There is also a text field labeled "Please detail actions necessary for compliance." In this field, you will find any miscellaneous details that you need to know in order to prepare for compliance.
- No- This response is used when the CPA is not acceptable and must be re-submitted.

In the event CPA negotiation is ongoing between the state and local health department (and exceeds the 30-day requirement), the local health department shall have the implementation period extended

accordingly. Implementation of approved plans must be in place for ninety days from the date of state agency approval before a local health department may be considered for accreditation.

Responses to CPAs may be viewed and tracked via the Web-based Reporting Module. Please see **page 12** for instructions on how to access the Reporting Module.

Please remember: ALL follow-up action after initial CPA response should be between the State agency program and the local health department. However, we ask that reviewers update CPA responses as necessary to communicate either final sign off or that the local health department has further implementation action to complete.

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

MLPHAP requires a local health department to request a re-evaluation for all MPR's and Indicator's that were found to be "Not Met" between ninety days of the CPA approval date, and one year of the accreditation evaluation. Failure to request a re-evaluation within one year will result in "Not Accredited" status.

Policy/Procedure

- The re-evaluation will assess only those MPR's and Indicator's found to be "Not Met" during the initial evaluation.
- The re-evaluation will encompass the time period beginning with the implementation of the CPA.

Evaluation

The evaluation will review the following:

- The deficiencies found in the original evaluation
- The CPA
- The action taken to resolve the deficiencies
- Results of the action

Extension Policy

If it appears that the local health department will not meet the agreed upon timeframe for implementation of a CPA(s), the local health department should contact the appropriate state agency as soon as the delay is evident. If necessary, the local health department may request an extension of the CPA

implementation date, documenting the extenuating circumstances that threaten the ability to meet the original date. The local health department request must be approved by the local governing entity prior to submission to the appropriate state agency. The state agency will then seek concurrence from other relevant state agencies and has final authority for approval.

180 and 90 Day CPA Process Emails

In order to further facilitate the CPA process between the three State agencies and the local health department, CPA reminder emails will be sent 180 and 90 days prior to the local health department's CPA implementation date if the agency still has outstanding CPAs. Emails will be sent by MPHI Accreditation staff with follow up response(s) required.

The following emails will be sent at the predefined CPA increments:

180 Day Email

To: Section Reviewer(s)
Cc: LHD Health Officer, LHD Accreditation Coordinator, Program Manager (at the state), and Local Health Services
Subject: Accreditation – Corrective Plan of Action

Hello Reviewer(s) Name(s),

It has come to MPHI's attention that Local Health Department Name has not completed the Corrective Plan of Action (CPA) process for the following CPAs:

Section: Family Planning
Indicators: 7.1, 11.1, 14.1, 16.1

We ask that you follow up with Local Health Department Name regarding the above CPAs as soon as possible. At this point, the LHD has 180 days remaining to fully implement the CPAs prior to their 365 day CPA implementation date of **list date here**. If the LHD reaches their 365 day CPA implementation date and the above CPAs are not fully implemented, the LHD's Accreditation status will be at risk.

If MPHI does not receive communication from you regarding the status of the above CPAs by insert date, the LHD's Health Officer, LHD Accreditation Coordinator, and your supervisor will be contacted to facilitate timely resolution of this matter.

I look forward to hearing from you very soon. Should you have any questions, please don't hesitate to contact me via email or by phone at (517) 324-8387.

Thank you,
Jessie Jones

90 Day Email

To: LHD Health Officer & Accreditation Coordinator
Cc: Section Reviewer(s), Program Manager(s) (at the state), and Local Health Services
Subject: Accreditation - Critical Status

Hello LHD Health Officer and Accreditation Coordinator Names,

It has come to MPHI's attention that Local Health Department Name has not completed the Corrective Plan of Action (CPA) process for the following CPAs:

Section: Family Planning
Indicators: 7.1, 11.1, 14.1, 16.1
(All sections and indicators will be noted)

Local Health Department Name has 90 days remaining to fully implement the above CPAs, including any follow-up visits needed, prior to your 365 day CPA implementation date of **list date here**. If a re-evaluation date has been set, please let us know the date of the re-evaluation for our records.

Your LHD is ninety days away from receiving not accredited status.

If you still need to schedule a re-evaluation, we ask that you communicate with your applicable section reviewers at the state and reply to this email by **list date here** letting us know the status of the above CPAs.

Should you have any questions, please don't hesitate to contact me via email or by phone at (517) 324-8387.

Thank you,
Jessie Jones

ACCREDITATION REVIEW EVALUATION
What to expect

Following Cycle 1 an ad hoc subcommittee of the Accreditation Commission, known as the Accreditation Quality Improvement Process (AQIP) workgroup implemented a survey with local health departments as part of an evaluation of the Accreditation program. The AQIP survey produced 44 recommendations to improve the Accreditation process. One of these recommendations identified the need to incorporate a review evaluation component. Feedback from the participants will be used to determine if concerns

expressed in the AQIP survey are being addressed. The data will help to identify training needs and aspects of the review process that may require improvement.

Procedure & Results

1. A copy of the Accreditation Review Evaluation **form is included in Appendix II.**
2. The survey is completed online, and can be found at this link: https://www.surveymonkey.com/r/QZGVYSH One survey should be completed per section reviewed after the results of the On-site Review have been retrieved. Regardless of how many individuals participated in the review, only one form per program is required.
3. De-identified evaluation results will be shared with the Accreditation Commission and state agency program managers.

ACCREDITATION COMMISSION

What to expect

Results from local health departments' On-Site Reviews are presented to the Accreditation Commission at the first Commission meeting after the health department's On-Site Review Report is finalized. These meetings occur four times per year, on the second Thursday of January, March, June, and September.

Initial Commission Review

A local health department retains its official Accredited status from one cycle to the next until the Michigan Departments of Health and Human Services, Agriculture and Rural Development, and Environmental Quality effect a subsequent decision pursuant to recommendations by the Accreditation Commission. The initial presentation that occurs to the Commission once the On-site Review is complete is simply to inform the Commissioners of the local health department's progress. No action is taken at this time. Please see **page 40** for subsequent steps.

Inquiry Policy

Local health departments that disagree with On-site Review findings or their Accreditation designation may request an Inquiry. If the findings in question relate to reviewer findings, as opposed to the Accreditation status designation, the local health department is encouraged to first contact the reviewer to seek a resolution before submitting in writing a request for an Inquiry. The first opportunity for this to occur is at the Exit Conference. However, the Inquiry may be submitted at any time during the three year accreditation cycle.

The purpose of the Inquiry is to convene the local health department and relevant state agency with a third party (Accreditation Commission Chair) to share information, discuss the issue and reach agreement.

If a mutually agreeable solution is not reached during this meeting, the Accreditation Commission Chair will render a decision in the form of a recommendation to the state agency with copies to the local health department. In all cases, final disposition is the responsibility of the state agency responsible for the program under question.

To begin the process, the local health department submits in writing a request for Inquiry with a short explanation that concisely describes what findings occurred and their reasons for taking exception to those findings. The request concludes with the local health department recommending an alternative finding. The request is submitted to the Chair of the Accreditation Commission, and in the case of an Inquiry for an On-site Review finding(s), copies are sent to the state agency that performed the On-site Review.

Within two weeks of receipt of the Inquiry request, the state agency that made the original findings will submit to the Accreditation Commission Chair a written summary of their rationale for the findings and an explanation as to why the local health department's position is not supportable.

Two weeks from receipt of the state agency written summary, the Chair of the Accreditation Commission will convene a meeting (usually by telephone) of the local health department and the state agency(s) involved, plus the MPHI Accreditation Coordinator and a representative from the lead state agency, Health and Human Services. Both the local health department and state agency(s) will present their positions to the Chair. If consensus cannot be reached by all parties during this meeting, within 5 business days the Chair will provide a recommendation and advise both the local health department and state agency(s). In all cases the decision to act upon the Accreditation Commission Chair's recommendation is up to the involved state agency(s).

Additional actions subsequent to the Inquiry shall be by and between the local health department and state agency(s) only.

BECOMING ACCREDITED – WHAT'S NEXT

What to expect

Once a local health department has completed the On-site Review and subsequent CPA process, the local health department has met the requirements to be recommended for Accreditation. The CPA implementation results are then shared with the Commission at its next quarterly meeting for recommendation to the Michigan Departments of Health and Human Services, Agriculture and Rural Development, and Environmental Quality for approval.

Immediately following the Commission's recommendation, a letter determining the local health department's status is then produced by the Director of the Michigan Department of Health and Human Services on behalf of the Directors of the Michigan Departments of Agriculture and Rural Development and Environmental Quality. The letter is sent to the local health department health officer and the chairperson of the local governing entity. A certificate of Accreditation accompanies the letter sent to the local health department.

Accreditation with Commendation

A local health department is eligible for Accreditation with Commendation when it:

- Meets 95%, cumulatively, of the Essential Indicators within the Minimum Program Requirements during the on-site reviews for the Powers and Duties and seven (7) mandated services* sections, and
- Misses not more than two (2) indicators in each of the programs cited above, and
- Has zero (0) repeat missed indicators from the previous cycle in each of the included programs, and
- Meets 80% of the Minimum Program Requirements in the Quality Improvement Supplement within the Powers and Duties Section.

* The seven mandated services sections include: Food Service Sanitation, Communicable Disease, Hearing, Immunization, Sexually Transmitted Disease, On-Site Wastewater, and Vision.

Next steps

It is suggested that local health departments consider taking the following actions upon becoming Accredited:

- Congratulate staff (breakfast/lunch, reception just for staff, etc.).
- Communicate effort/achievement to local governing entity (invite them to award ceremony, special presentation/update at regular meeting, or call a special meeting to announce).
- Inform the community: media (newspaper(s), local news, public, and newsletters).
- Include in local health department marketing efforts Accreditation designation; include designation as a tagline on pamphlets and letterhead, multiple certificates for multiple offices, etc.

Appendix I: Scheduling Guidance

Scheduling Guidance

1. Schedule Section I (Local Heatlh Department Powers and Duties) and the optional Quality Improvement Supplement (if applicable) on Monday. The optional Quality Improvement Supplement is reviewed remotely.

2. Section III (General Communicable Disease) will be reviewed remotely. Guidance for the remote review begins on page 53 of this guide. Please to be sure to indicate a day and time for the reviewers to contact your health department to discuss their review of your materials.

3. Section IV (Hearing), as a single half-day review, (e.g., IV 9-12 noon). Please schedule separately from Vision, if possible.

4. Schedule a family planning clinic on the first day of the two-day Family Planning (Section X) review. Agencies should schedule a full clinic with a variety of visit types, especially initial and annual visits.

5. For Section V (Immunization), schedule one day for the review at the main local health department clinic (no visits to off-site clinics) on a day when the IAP coordinator and immunization clerk are available for interaction with the reviewer.

6. Section IX (Breast and Cervical Cancer Control Navigation Program) will be reviewed remotely. Please to be sure to indicate a day and time for the reviewers to contact your health department to discuss their review of your materials.

7. Please avoid scheduling Section XII (Children's Special Health Care Services) on Wednesday or Friday.

SECTION	TIME REQUIRED
Section I – Local Health Department Powers and Duties and optional Quality Improvement Supplement (if applicable)	1day
Section II – Food Service Sanitation Program	5 days
Section III - General Communicable Disease Control	½ day Reviewed remotely
Section IV – Hearing	½ day
Section V – Immunization	1 day
Section VI – On-site Wastewater Treatment Management	2 days
Section VII – HIV/AIDs and Sexually Transmitted Disease	1 day
Section VIII – Vision	½ day
Section IX – Breast and Cervical Cancer Control Program	½ day Reviewed remotely
Section X – Family Planning	2 days
Section XI – Women, Infant, and Children (WIC)	N/A – no on-site review required
Section XII – Children's Special Health Care Services (CSHCS)	1 day

Appendix II: Program Specific Guidance

Quality Improvement Supplement

QIS Review Process

The Quality Improvement Supplement (QIS) to the Powers and Duties review has been revised for Cycle 6 of the Michigan Local Public Health Accreditation Program to better align with Domain 9 of the Public Health Accreditation Board (PHAB) national public health accreditation program. Additionally, there is a new process for review of documentation related to the QIS. If a local health department (LHD) indicates in their pre-materials that they are planning to participate in the QIS, documentation must be submitted ahead of time.

Local health departments (LHDs) that are participating in the QIS must submit documentation related to the QIS **two weeks** prior to their scheduled on-site review. All documents need to be emailed to Jessie Jones (jjones@mphi.org) and Jeanette Ball (jball@mphi.org) at the Michigan Public Health Institute (MPHI). Please complete the cover sheet included below in order to identify which documents are intended to fulfil which indicator. Please also provide the name and contact information of a staff member who MPHI staff can contact with any questions. MPHI staff will review documentation within one week and send back any questions.

Once all questions have been answered, MPHI will finalize their recommendations and provide them to Local Health Services staff prior to the on-site review. MPHI will also participate in the LHD's on-site review and/or exit conference via conference call or in person.

QIS Documentation

Below is a list of required documentation for the QIS review:

Indicator 1.1: Staff at all organizational levels are engaged in establishing and/or updating a performance management system.

- Documentation that the agency leadership is engaged in setting a policy for and/or establishing a performance management system for the department, for example: strategic and operational plans; training agendas; meeting agendas, packets, materials, and minutes; draft policies or items discussed with the governing entity, and/or presentations to the governing entity.
- Meeting agendas, materials, minutes, orientation materials, and/or plans that show staff at all levels are engaged in determining the nature of a performance management system for the department and implementing the system.

Indicator 1.2: The agency has adopted a department-wide performance management system.

- A written description of the department's adopted performance management system that includes:
    - Performance standards, including goals, targets, and indicators, and the communication of expectations.
    - Performance measurement, including data systems and collection.

- Progress reporting including analysis of data, communication of analysis results, and a regular reporting cycle.
- A process to use data analysis and manage change for quality improvement (QI) toward creating a learning organization.

Indicator1.3: The agency has implemented a performance management system.

- Agendas, minutes, reports, or protocols from the performance management committee or team.
- Documentation identifying goals and objectives included in the performance management system, with identified time frames for measurement.
- Documentation showing how the agency actively monitors performance toward stated goals and objectives.
- Documentation of how the agency identifies areas for improvement through analysis of performance management data.
- Documentation of next steps taken when areas for improvement were identified.
- A completed performance management self-assessment that reflects the extent to which performance management practices are being used.

Indicator 1.4: The agency systematically assesses customer satisfaction with agency services and makes improvements.

- Description or policy regarding how the agency collects, analyzes, and uses customer/stakeholder feedback.
- Examples of instruments to collect customer/stakeholder satisfaction including forms, surveys, focus groups, or other methods.
- Report, memo, or other written document describing how the agency has used results and actions taken based on the collection, analysis, and conclusions drawn from feedback from customer groups.

Indicator 1.5: The agency provides opportunities for staff involvement in the department's performance management.

- Documentation of agency staff participation in performance management training.

Indicator 2.1: The agency has established a QI program based on organizational policies and direction.

- Agency QI Plan, including:
  - Key quality terms
  - Current and desired future state of quality in the organization
  - Key elements of the QI effort's structure (group or committee, membership, roles and responsibilities, etc.)
  - QI training available and conducted
  - Project identification, and how it is aligned with department's strategic direction and performance management plan
  - QI goals, objectives, and measures with time-framed targets

- How the plan is monitored and evaluated
- How QI efforts are communicated

Indicator 2.2: Engage local governing entity in establishing organizational policies and direction for implementing QI.

- Local governing entity meeting agenda and minutes discussing establishment of QI policies and direction for implementation within agency.

Indicator 2.3: The agency has implemented QI activities

- Evidence of QI Plan implementation.
- Evidence of implementation of QI activities and the agency's application of its process improvement model.

Indicator 2.4: Assure QI training and technical assistance are available to staff.

- 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.

For Questions

If you have any questions or need further information, please contact Jessie Jones at jjones@mphi.org or 517-324-8387, or Jeanette ball at jball@mphi.org or 517-324-6019.

QIS Cover Sheet

Staff Contact Information

Please provide contact information for the person who should be contacted with any questions regarding the QIS:

Name:
Email:
Phone Number:

MPR 1: Use a performance management system to monitor achievement of organizational objectives

Indicator	File name	Policy Title/ specific page numbers that address the indicator
Indicator 1.1 Staff at all organizational levels are engaged in establishing and/or updating a performance management system.		
Indicator 1.2 The agency has adopted a department-wide performance management system.[1]		
Indicator 1.3 The agency has implemented a performance management system.[2]		
Indicator 1.4 The agency systematically assesses customer satisfaction with agency services and makes improvements.		
Indicator 1.5 The agency provides opportunities for staff involvement in the department's performance management.		

MPR 2: Develop and implement quality improvement processes integrated into organizational practice, programs, processes, and interventions

Indicator	File name	Policy Title/ specific page numbers that address the indicator
Indicator 2.1 The agency has established a QI program based on organizational policies and direction.		
Indicator 2.2		

[1] Or is in the process of adopting a department-wide performance management system.
[2] Or has plans for implementing a performance management system that incorporates the stated requirements.

Engage local governing entity in establishing organizational policies and direction for implementing QI.		
Indicator 2.3 The agency has implemented QI activities.		
Indicator 2.4 Assure QI training and technical assistance are available to staff.		

SECTION III
General Communicable Disease Control

Remote Accreditation Guidance

Overview
Starting with accreditation Cycle 5, the Section III: General Communicable Disease Control will be conducted via an off-site remote accreditation process. The communicable disease accreditation team is asking local health departments (LHD) to upload all Section III related documents to the MiHAN for the remote accreditation. This will allow a standard system for sharing files during the accreditation process.

The **Document Center** on the MiHAN has folders for each of the LHDs in Michigan. Within the folder for each LHD there is a folder entitled "***LHD name* CD Accreditation**". Access is restricted to only those local and state personnel who have been given permission to view the documents within the folder.

In the Accreditation folder on the Han you will find the "Accreditation Evidence Crosswalk" document. Please complete this document and post it back to the folder as it directs the reviewer through your evidence. This ensures all documents you feel provide support for a specific MPR/indicator are reviewed. Please post all supporting materials and the completed Crosswalk document to the accreditation folder no later than 8 A.M. on the morning of your scheduled Section III: General Communicable Disease review date. The reviewer conducting your evaluation will contact you prior to the week of your accreditation to schedule a conference call exit interview, if one is requested.

If at any time you have questions or difficulty with the process, please contact the reviewer assigned to your department's accreditation.

Items to include in the Accreditation folder
Please refer to the Section IV MPRs and indicators for specific suggested/required materials and documents to be placed in the folder as evidence. Provided evidence should include:

- Completed Accreditation Evidence Crosswalk document
- Electronic copies of all communicable disease policies, procedures, and protocols as specified in the Section III tool
- Electronic weekly MDSS line lists with documented review and approval (or other electronic logs – e.g., an Excel workbook)
- Electronic copies of the annual reports, formal summaries, or website address where 3 years of communicable disease trend data is maintained
- List of stakeholders receiving the annual report or formal summary
- Electronic versions of quarterly updates or newsletters (Special Recognition)
- A list of all disease specific protocols maintained by the LHD and 3-5 representative samples of these protocols
- A sample of 3-5 outbreak summaries for investigations conducted during the previous 3 years
- A sample of 3-5 fact sheets, educational materials, or guidance documents used by the LHD

- Electronic copies of presentations given at educational venues (Special Recognition)
- List of current and up-to-date reference materials maintained by the LHD
- Logs of professional development activities (CEU, CME, or contact hours) for at least the CD Supervisor and one other CD Nurse during the previous 3 years.
- Signature pages that represent internal review and approval for all policies, procedures, and protocols

Retrieving a document from the HAN CD Accreditation Folder

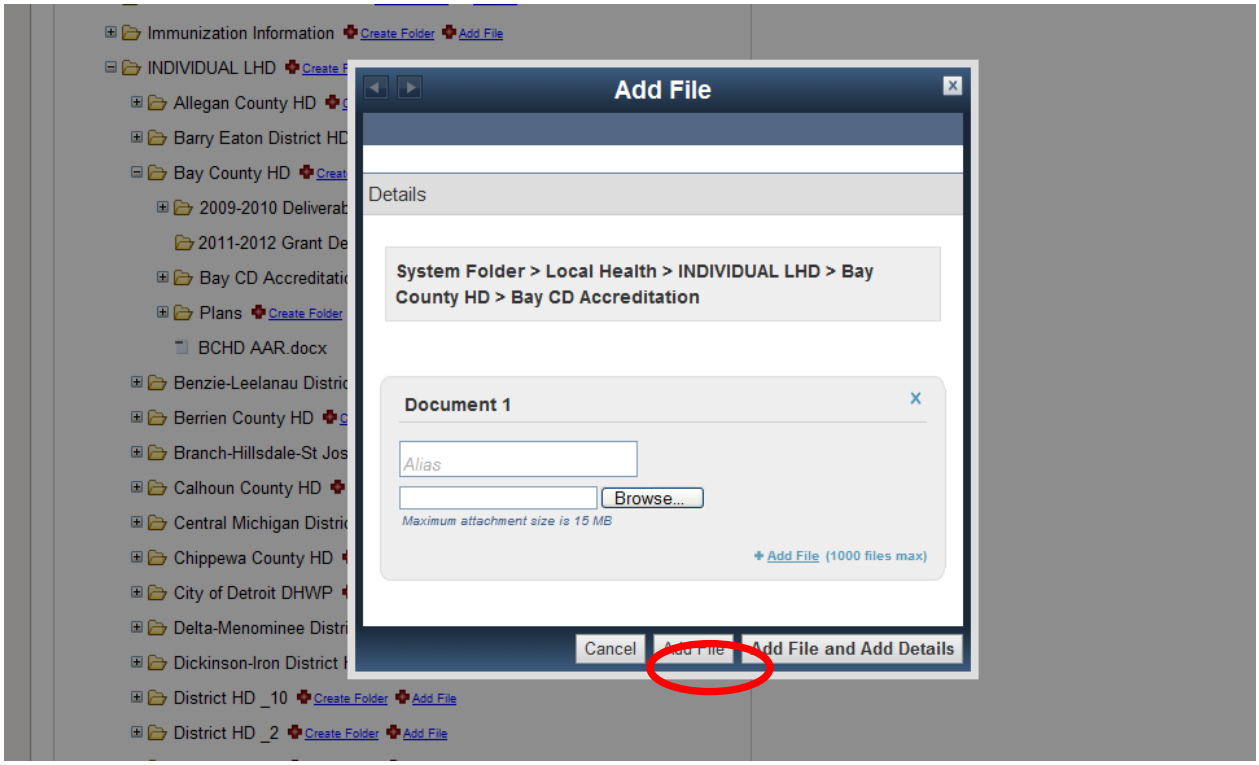
1. Log on to MiHAN (https://michiganhan.org)
2. Select 'Document Center' at the top of the page
3. Select 'LOCAL HEALTH' folder

4. Select 'INDIVIDUAL LHD' folder

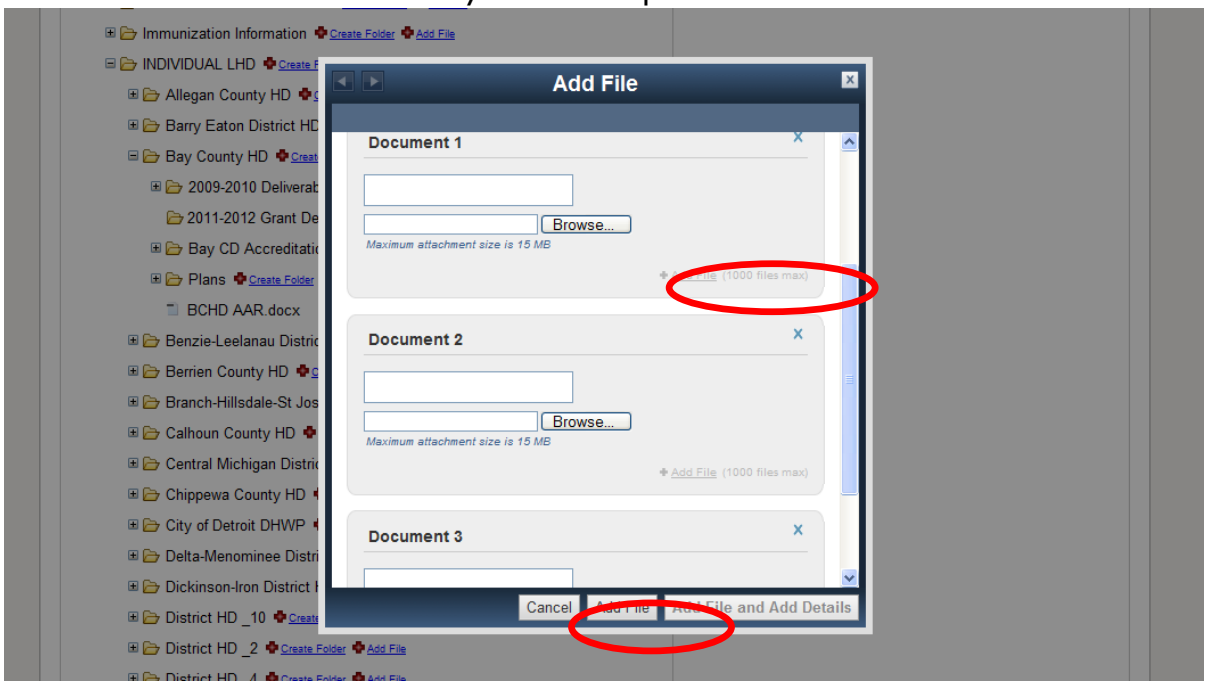
5. Select your local health department
6. Select the folder *LHD name* CD Accreditation
7. Select the document you would like to access

Uploading a document to the HAN CD Accreditation Folder

1. Log on to MiHAN (https://michiganhan.org)
2. Select 'Document Center' at the top of the page
3. Select 'LOCAL HEALTH' folder
4. Select 'INDIVIDUAL LHD' folder
5. Select your local health department
6. Select the folder *LHD name* CD Accreditation
7. Click on the "Add File" icon.
8. If you choose to upload a single document at a time you see the following screen
    a. Click on the Browse button to search your computer files
    b. Once the document is found, select "Add File"



9. If you choose to upload multiple documents:
   a. Select 'Add File (1000 files max)'
   b. Repeat this process for as many files as you wish to upload.
   c. When all of the files you wish to upload have been selected click on "Add File.



Section III: Accreditation Evidence Crosswalk

Please complete this document prior to the scheduled review date and post back to your folder on the MiHAN. Completion of this document is important for making the connection between the specific indicator and the supporting documents.

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.

Indicator	File name / web address LHD is submitting as evidence for the indicator	Policy title / specific page numbers that address indicator
Indicator 1.1 The local health department shall maintain annually reviewed policies and procedures.		
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.		
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 MDHHS 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 no additional information is required for this indicator.	Not Applicable	Not Applicable
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.		

MPR 2
The local health department shall perform investigations of communicable diseases as required by Michigan law.

Indicator	File name / web address LHD is submitting as evidence for the indicator	Policy title / specific page numbers that address indicator
Indicator 2.1 The local health department shall maintain annually reviewed policies and procedures.		
Indicator 2.2 The local health department shall initiate communicable disease investigations as required by Michigan laws, rules, and/or executive orders.		
Indicator 2.3 The local health department shall notify MDHHS immediately of a suspected communicable disease outbreak in their jurisdiction.		

MPR 3

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

Indicator	File name / web address LHD is submitting as evidence for the indicator	Policy title / specific page numbers that address indicator
Indicator 3.1 The local health department shall maintain annually reviewed policies and procedures.		
Indicator 3.2 The local health department performs activities necessary for case follow-up, which includes guidance to prevent disease transmission.		
Indicator 3.3 Presence of adequately prepared staff capable of enforcing Michigan law governing the control of communicable diseases.		
Indicator 3.4 The local health department shall complete and submit the necessary foodborne or waterborne outbreak investigation forms. Reviewer will pull CDC 52.12 and 52.13s submitted by LHD – no action is required by LHD.	Not Applicable	Not Applicable

SECTION VI
On-Site Wastewater Treatment Management

Michigan Department of Environmental Quality
Environmental Health Programs Unit

_____
(Name of Local Health Department)

ANNUAL SELF-ASSESSMENT

On-Site Wastewater Treatment Management Program

Annual Self-Assessment Period Covered
From: _____ **To:** _____
(Date) **(Date)**

Note: The data to be submitted for this Annual Self-Assessment is to be representative of the reporting period identified above.

INFORMATION

PLEASE REFER TO:

MPR Indicator Guide: Section VI, On-Site Wastewater Treatment Management

Appendix E –Self-Assessment Review Option

Self-Assessment Form 1 – Document Review Log

_____ _____
Local Health Department Signature **Date**

_____
Title

INDICATOR 1.1 - Legally Adopted On-Site Wastewater Treatment Regulation

Name of Regulation:

Date of formal adoption of most recent revision: **by**

Are code modifications now under consideration? ☐ **Yes** ☐ **No**

If yes, please describe and indicate anticipated timetable for adoption:

Has the current code been made available to all staff? ☐ **Yes** ☐ **No**

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 1.2 - Enforcement Measures

Code provisions exist that establish the following enforcement measures:

Denial of permits for on-site systems? ☐ Yes ☐ No Code Reference:

Ability to issue orders to correct or abate? ☐ Yes ☐ No Code Reference:

Appearance Tickets? ☐ Yes ☐ No Code Reference:

Civil Penalties? ☐ Yes ☐ No Code Reference:

Issue orders to correct imminent danger? ☐ Yes ☐ No Code Reference:

Allows an appeals process? ☐ Yes ☐ No Code Reference:

Written policies and procedures exist that provide uniform procedures for enforcement
☐ Yes ☐ No

The authority and function of the appeals board clearly defined by code or formal policy? ☐ Yes ☐ No

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 1.3 - Evidence of Enforcement Measures

Are records of the following enforcement activities available?

- **Denials of on-site permits:** ☐ **Yes** ☐ **No** **If yes, number:**
- **Correction orders for failed systems:** ☐ **Yes** ☐ **No** **If yes, number:**
- **Orders to correct construction violations:** ☐ **Yes** ☐ **No** **If yes, number:**
- **Formal actions against installers** ☐ **Yes** ☐ **No** **If yes, number:**

Note: The above data is to be representative of the reporting period as identified on Page 1.

Describe how records of enforcement activities are kept:

For the self-assessment period, please indicate the number of formal appeals filed: and number granted:

Where granted, are appeals within the authority of the regulation? ☐ **Yes** ☐ **No**

Comments:

<u>Compliance Evaluation</u>

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 2.1 - Site Evaluation Documentation

How many site evaluations were performed this self-assessment period in conjunction with application for a permit?

Based upon Appendix A (Permit Selection Protocol) the minimum number of permit files required to be assessed is:

The actual number of permit files reviewed for this annual self-assessment period was:

☐ **Please utilize and attach copies of completed Self-Assessment Form 1 (Sewage Treatment and Dispersal Document Review Log) for all reviews completed this self-assessment period.**

What percent of site evaluations reviewed captured all essential elements described in section 2.1 and Appendix B of the MPR Indicator Guide?

☐ **For the reviews completed and logged please attach a representative copy of one site evaluation for each staff member's work reviewed.**

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 2.2 - Permit Documentation

How many permits were issued during this self-assessment period in conjunction with application for a permit?

Based upon Appendix A (Permit Selection Protocol) the minimum number of permit files required to be assessed is:

The actual number of permit files reviewed for this annual self-assessment period was:

☐ **Please utilize and attach copies of completed Self-Assessment Form 1 (Sewage Treatment and Dispersal Document Review Log) for all reviews completed this self-assessment period.**

What percent of permits issued and reviewed captured all essential elements described in section 2.2 of the MPR Indicator Guide?

☐ **For the reviews completed and logged please attach a representative copy of one permit for each staff member's work reviewed.**

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 2.3 - Organized Filing System

Please describe the filing organizational structure for individual site evaluations and sewage permits:

Are records for commercial on-site systems maintained separately? ☐ **Yes** ☐ **No**

Please describe the filing structure for subdivision and condominium review and approval:

Are files maintained electronically? ☐ **Yes** ☐ **No** **If yes, please describe your internal process:**

How long are records maintained?

Are files maintained up-to-date? ☐ **Yes** ☐ **No**

Describe the process for tracking of site evaluations and permits:

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 3.1 - Final Inspection Documentation

How many final inspections were conducted during this self-assessment period?

Based upon Appendix A (Permit Selection Protocol) the minimum number of permit files required to be assessed is:

The actual number of permit files reviewed for this annual self-assessment period was:

☐ **Please utilize and attach copies of completed Self-Assessment Form 1 (Sewage Treatment and Dispersal Document Review Log) for all reviews completed this self-assessment period.**

What percent of completed final inspections reviewed captured all essential elements described in section 3.1 and Appendix C of the MPR Indicator Guide?

☐ **For the reviews completed and logged, please attach a representative copy of one final inspection document for each staff member's work reviewed.**

Are installer affidavits used to document a final inspection in lieu of health department final inspections? ☐ Yes ☐ No If yes, please complete the following:

- **The number that were received during this self-assessment period:**
- **Are the installer affidavits reviewed for documentation in accordance with the essential elements for this indicator? ☐ Yes ☐ No**

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 4.1 - Complaint Investigation and Documentation

Relative to sewage complaints:

Is there established guidance for complaint investigation? ☐ **Yes** ☐ **No**

Complaints are investigated and final resolution documented? ☐ **Yes** ☐ **No**

Is a standardized form utilized for complaints? ☐ **Yes** ☐ **No** **If yes, please attach a copy.**

Describe how complaints are assigned:

Who is responsible for tracking progress leading to complaint resolution?

Describe the process for logging and tracking complaints:

Describe how complaints are filed.

During this self-assessment period: **Number of sewage complaints received:**

Number of sewage complaints resolved:

Number of sewage complaints pending:

Comments:

Compliance Evaluation

☐ **Met**

☐ **Met with Conditions**

Conditions:

☐ **Not Met**

Describe reasons:

INDICATOR 5.1 - Failed System Evaluation

A standard form is available for recording failed system data? ☐ **Yes** ☐ **No**

Please attach copy of form used or describe method of data collection:

There is an on-going or periodic quality assurance review of failed system evaluations to assess that all minimum elements are being reported? ☐ **Yes** ☐ **No**

Describe the quality assurance process:

Please describe the filing system and/or computer database which used to retain failed system data?

Is an annual summary of data is compiled and transmitted to the Department of Environmental Quality in accordance with Appendix D (Failed System Evaluation Data Collection and Submissions)? ☐ **Yes** ☐ **No**

Date of most recent summary:

Comments:

Compliance Evaluation

☐ **Met**

☐ **Not Met**

Describe reasons:

SECTION IX
Breast and Cervical Cancer Control Program

Remote Accreditation Guidance

Overview

Starting with accreditation Cycle 6, the Section IX: Breast and Cervical Cancer Control Program (BCCCNP) will be conducted via an off-site remote accreditation process. The BCCCNP accreditation team is asking local health departments (LHD) to upload all Section IX related documents to the MDHHS File Transfer site or fax documents for the remote accreditation. This will allow a standard system for sharing files during the accreditation process.

The MDHHS File Transfer has folders for each of the LHDs in Michigan. Access is restricted to only those local and state personnel who have been given permission to view the documents within the folder.

In the MDHHS File Transfer folder you will find the "Accreditation Evidence Crosswalk" document. Please complete this document and post it back to the folder as it directs the reviewer through your evidence. This ensures all documents you feel provide support for a specific MPR/indicator are reviewed. Please post (or fax) all supporting materials and the completed Crosswalk document to MDHHS File Transfer no later than 8 A.M. on the morning of your scheduled Section IX: Breast and Cervical Cancer Control Program review date. The reviewer conducting your evaluation will contact you prior to the week of your accreditation to schedule a conference call exit interview, if one is requested.

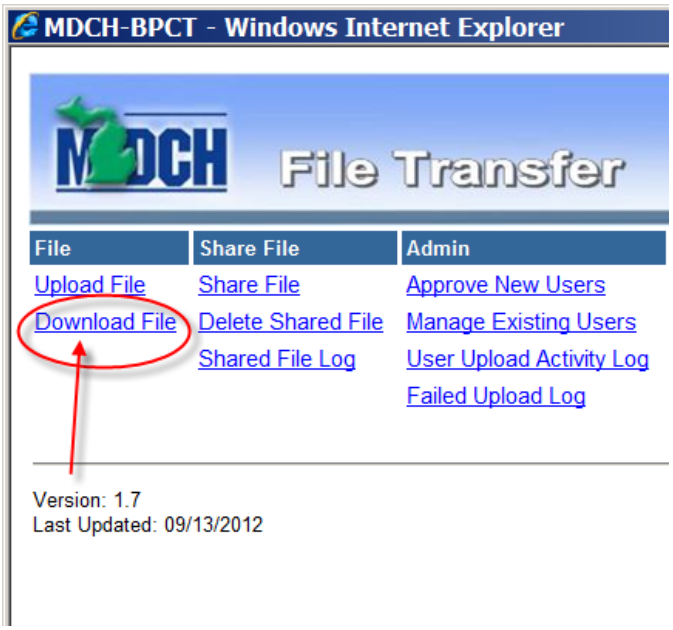
If at any time you have questions or difficulty with the process, please contact the reviewer assigned to your department's accreditation.

Items to include
Please refer to the Section IX MPRs and indicators for specific suggested/required materials and documents to be placed on MDHHS File Transfer as evidence. Provided evidence should include:

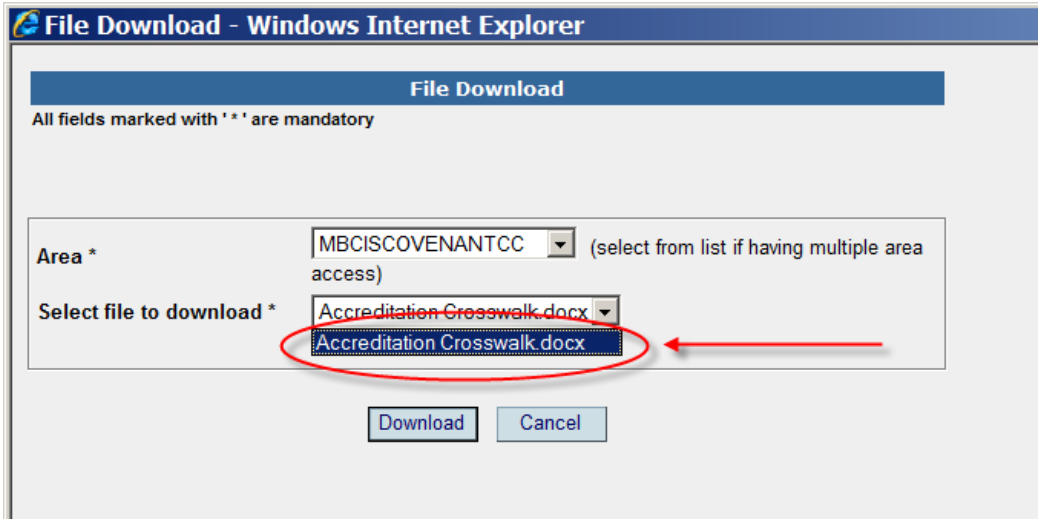
- Completed Accreditation Evidence Crosswalk document
- Electronic copies of all BCCCNP policies, procedures, and protocols as specified in the Section IX tool

Retrieving a document from the DCH File Transfer Folder

1. Log on to DCH File Transfer (https://sso.state.mi.us)
   If you do not have access, contact Tory Doney @ DoneyT@michigan.gov.
2. Select 'DCH File Transfer'
3. Select 'Download File'

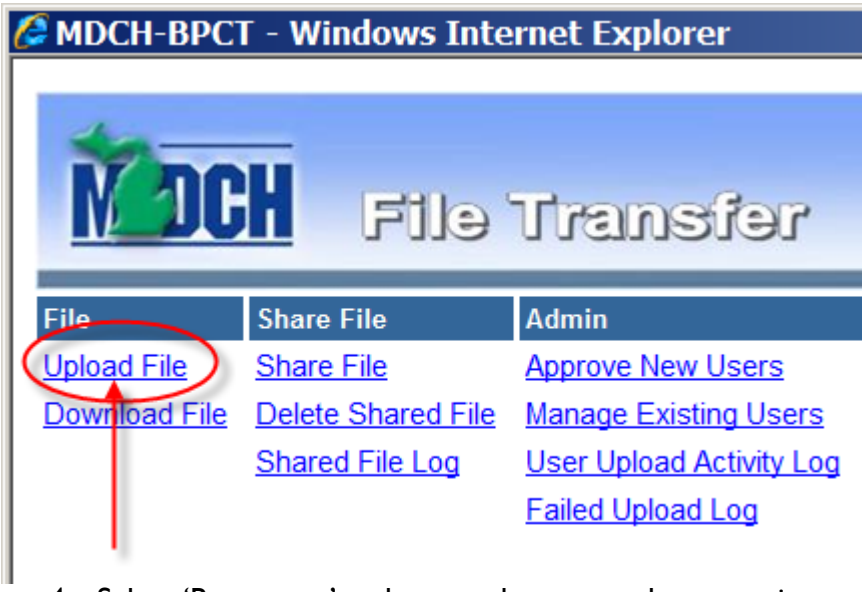


4. Select the document you would like to access

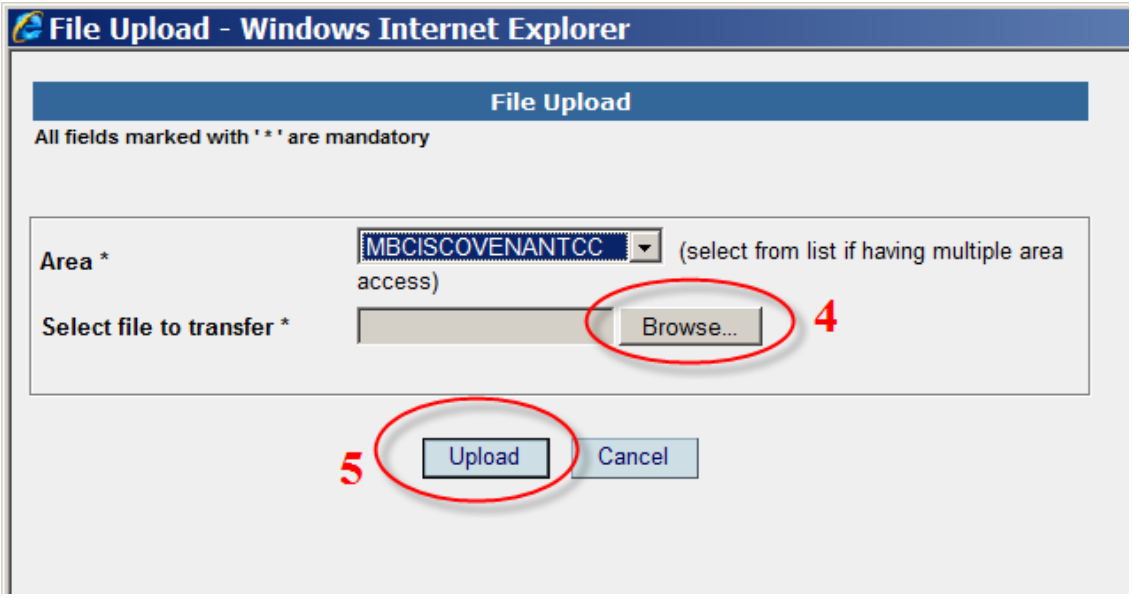


Uploading a document to the DCH File Transfer Folder

1. Log on to DCH File Transfer (https://sso.state.mi.us)
   If you do not have access, contact Tory Doney at DoneyT@michigan.gov.
2. Select 'DCH File Transfer'
3. Select 'Upload File'



4. Select 'Browse …' and go to where your document is saved on your computer
5. Select 'Upload'
   a. Repeat this process for as many files as you wish to upload.
   b. *NOTE* You can only upload ONE file at a time.



Section IX: BCCCNP Accreditation Indicators Evidence

Please complete this document prior to the scheduled review date and either fax the appropriate documents or post back to your folder on the MDHHS File Transfer. Completion of this document is important for matching the specific indicator to its supporting documents. Faxes should be sent to Tory Doney at 517-335-8752

MPR 1

Coordinate with MDHHS 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

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DHHS File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
None	**Not Applicable**	**Not Applicable**	**Not Applicable**

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 BCCCNP 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 (if appropriate).

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Written policy outlining the procedure for gathering clinical service data from each BCCCNP provider/clinic, verifying the accuracy of the data, and communicating important program information/changes to BCCCNP staff at the local health department and subcontracted provider staff	**[ ] Fax** **[ ] DCH File Transfer**		

2. TWO EXAMPLES NEEDED of evidence showing correspondence/ emails/ memos/phone calls/meeting minutes to providers within the last 6 months	**[ ] Fax ONLY**	Not Applicable	

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 expand/maintain the BCCCNP delivery network, are planned and implemented with involvement from other healthcare organizations (E.g Federally Qualified Healthcare Centers) and community groups representing priority populations.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. TWO EXAMPLES NEEDED of documentation of meeting minutes, phone calls, emails, written correspondence, etc). showing collaboration with community/other healthcare organizations representing target populations.	**[ ] Fax ONLY**	Not Applicable	

MPR 4

Recruit women eligible for the BCCCNP, giving priority to minorities and women aged 50 to 64 and women who have previously been screened through the BCCCNP.

References: PL 101-354, Sections 1501 (a)(3) and 1504 (a); CDC Administrative Guidance.

Indicator 4.1

Recruit women eligible for the BCCCNP based on program criteria (age, income, and insurance status) for identifying target populations as defined by CDC and federal law. 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).

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Written evidence (procedure) describing how the agency has used and compared data from the BCCCNP database with the current demographic information to ensure that it serves individual minority populations outlined under the indicator.	**[ ] Fax** **[ ] DCH File Transfer**		

MPR 5

Assure that screening and follow-up services meet program requirements as specified by adherence to the BCCCNP 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).

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 5.1
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 BCCCNP medical protocol.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Copy of policy/procedure describing the process for • Distributing and reviewing the BCCCNP Medical Protocol with contracted providers and • Addressing non-adherence to the medical protocol in delivering screening and/or diagnostic clinical services.	**[ ] Fax** **[ ] DCH File Transfer**		

Indicator 5.2
The local coordinating agency provides evidence describing their role in assisting women to obtain needed cancer treatment services.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Written policy/procedure describing the process for assisting program women with obtaining cancer treatment.	**[ ] Fax** **[ ] DCH File Transfer**		

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 BCCCNP that includes explaining the process for obtaining the client's informed consent and release of medical information. The informed consent MUST include the following information:

1. Program eligibility 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
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.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
Written policy/procedure describing the process for assuring completion of all appropriate paperwork by the client in addition to # 1-4 listed under the indicator:	**[ ] Fax** **[ ] DCH File Transfer**		

MPR 7

Assure compliance with the "funds of last resort" requirement in the federal law.

Reference: PL 101-354, Section 1504 (d)(1)(2).

Indicator 7.1
Each client's eligibility is reviewed at the time of enrollment and at each rescreening visit. Based upon BCCCNP's current Eligibility Requirement Policy, for underinsured clients, 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.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. An example of a front and back copy of TWO underinsured client's insurance card (WITH NAME AND IDENTIFYING INFORMATION BLACKED OUT) that is made at the time of enrollment and each rescreening visit	**[ ] Fax ONLY**	Not Applicable	
2. Written policy outlining steps/procedures for determining BCCCNP eligibility for insured women.	**[ ] Fax** **[ ] DCH File Transfer**		

MPR 8

There is a system in place to monitor and take corrective action as appropriate, to assure that the reimbursement amount for each BCCCNP approved service is accepted as payment in full.

References: PL 101-354, amended Section 402 (a)(1)(3); CDC Administrative Guidance.

Indicator 8.1

Fully executed, current, written arrangements, consistent with BCCCNP 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 BCCCNP clinical service provider. The local coordinating agency provides documentation of contract language stating that the provider:

1. Agrees to accept up to the BCCCNP reimbursement rate as payment in full (less insurance payment) for each BCCCNP service; **AND**

2. Has agreed, to the best of their ability, to not bill any BCCCNP client for any service that is partially or fully covered by the BCCCNP reimbursement amount for that service or similar language; **AND**

3. That outlines corrective measures that will be implemented when inappropriate billing occurs. Inappropriate billing is defined as the following:
   - Billing the BCCCNP for services that are not part of the BCCCNP reimbursement rate schedule
   - Balance billing the client for charges above the BCCCNP approved reimbursement rate

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Five copies of signed BCCCNP clinical service provider contracts or letters of agreement from last fiscal year as identified by MDHHS Reviewer.	**[ ] Fax ONLY**	**Not Applicable**	

Indicator 8.2

Assure that providers are provided a copy of the BCCCNP Unit Cost Reimbursement Rate Schedule which indicates the maximum rates for BCCCNP screening and diagnostic services. Providers may bill the MDHHS Cancer Prevention and Control Section billing service up to the usual and customary charge; however, the reimbursement amount, will not exceed the BCCCNP approved rates.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
TWO EXAMPLES OF Copies of any communications with providers documenting all updates of BCCCNP Unit Cost Reimbursement Rate Schedules that ended the previous fiscal	**[ ] Fax ONLY**	**Not Applicable**	

MPR 9

Maintain, and utilize a computerized system (i.e., Michigan Breast and Cervical Cancer Control Information System-{MBCIS}, Agency Identified Reports Database) for tracking and monitoring clients.

References: PL 101-354, Section 1501 (a)(6); CDC Administrative Guidance; CDC Performance Indicators.

Indicator 9.1

A tracking system is used to monitor and guide care-coordination , case management, patient navigation services in providing screening, and/or associated follow-up care for eligible program 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 BCCCNP Medical Protocol
2. Plan for using agency identified reports database in for:
   - Tracking and notifying program women requiring short-term follow-up
   - Identifying and notifying eligible women with normal test results when next annual screening visit is scheduled.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
1. Name of staff member who is the lead Discoverer user at the agency responsible for Discoverer reports	**[ ] Fax ONLY**	**Not Applicable**	
2. Written process/procedure identifying plan for using Case Management and Discoverer reports to track care provided to program women.	**[ ] Fax** **[ ] DCH File Transfer**		

Indicator 9.2

Evidence is available through analysis of MBCIS DATA that demonstrates timeliness of clinical services as defined by the CDC TIMELINES Indicators:

a) 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**

b) 80% of clients with cancer diagnoses begin treatment within 60 days of the final diagnosis.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
NONE. Evaluated separately prior to review by MDHHS Nurse Consultant. No documentation needs to be sent to MDHHS	**Not Applicable**	**Not Applicable**	**Not Applicable**

Indicator 9.3

Review of CDC Completeness Performance Indicator Data in BCCCNP 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)

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
NONE. Evaluated separately prior to review by MDHHS Nurse Consultant. No documentation needs to be sent to MDHHS	**Not Applicable**	**Not Applicable**	**Not Applicable**

Indicator 9.4
All individuals that access MBCIS have a completed, signed Secured Application User Agreement Access form on file at MDHHS/Cancer Prevention and Control Section.

Documentation Required	MDHHS Documentation sent via Fax or DCH File Transfer (Check appropriate box)	For DCH File Transfer: List file name submitted as evidence for the indicator	Policy title / specific page numbers that address indicator
Copy of MBCIS user agreements with specific notation of those with "clinical" access and Discoverer access.	**[ ] Fax ONLY**	**Not Applicable**	

SECTION X
Family Planning Program

These advance materials must be sent directly to the Family Planning program:

1. Current organizational chart with names, positions and FTE's listed, and curricula vitae or resumes of project director and medical director.
2. Clinical protocol manual, including applicable STD protocols.
3. Copy of forms/templates used in the client record.
4. Completed Fiscal Questionnaire.

MATERIALS TO BE AVAILABLE ON SITE (DO NOT MAIL TO MPHI):

1. Client records will be randomly selected based on visit type, abnormal pap follow-up, adolescent status or choice of contraceptive method.
2. Family planning administrative, legal and financial policies.
3. Roster for the Family Planning Advisory Committee, identifying the type of community representation members hold.
4. Meeting minutes from the Family Planning Advisory Committee and Information and Education (I&E) Committee from the last three years.
5. Samples of billing, registration, encounter and data processing forms.
6. Client charge schedule and current sliding fee schedule.
7. Current referral listing.
8. Written letters of agreement for paid referrals. Also include your written policy for after-hours emergency contact.
9. Documentation of quality assurance activities, including: medical audits, chart audits, and quality assurance committee minutes or staff minutes that address quality assurance issues.
10. New staff orientation plan.
11. Documentation of clinic in-service training and other staff training, identifying staff attendance.
12. A copy of the stock or supply list and the price list for these items.
13. Equipment maintenance logs.
14. CLIA logs.
15. OSHA exposure control policy.
16. Copies of medical director's professional license; drug control license for each service site; nursing licenses; and professional license for each clinical care provider.
17. Documentation of client input, such as client satisfaction surveys.
18. Educational materials, including pamphlets, tear off sheets and videos.
19. Outreach and community education logs.
20. Documentation of most recent clinical evaluations/peer reviews for all clinicians.
21. Laboratory manual.
22. Formulary.
23. Appointment schedule.
24. Staff evaluations.
25. Medication education sheets.
26. Staff CPR certification.
27. Most current family planning cost study.
28. Single Audit Review.

Title X Family Planning

Pre-Site Review Fiscal Review Questionnaire

Agency Name: _____

Date of Review: _____

Allowable Costs/Cost Principles:	Yes/No/NA	Comments	Consultant Review/Observations	
			A/U	Comments
1. Is staff aware of applicable cost principles (OMB Circular A-87 or A-122) and unallowable costs (i.e., alcoholic beverages, bad debts, contingency reserves, contributions and donations, entertainment, fund raising, etc.?) http://www.whitehouse.gov/omb/circulars/a087/a087-all.html http://www.whitehouse.gov/omb/circulars/a122/a122_2004.pdf				
2. Does the accounting system have separate revenue and expense accounts for the Family Planning Programs?				

3. For the most recent completed grant year, do the general ledger revenue and expense accounts for the MDHHS Family Planning grant agree with payment made by MDHHS, and the final FSR submitted for that grant year? If not, explain.				
4. Do management and Board of Directors regularly review a functional budget compared to actual expenses for each funding source and program?				
5. Do management and Board of Directors have procedures in place to follow-up on budget variances if they occur?				
6. Does the agency have an annual financial statement audit or a single audit?				
7. Have financial audit findings been corrected or addressed?				

8. Does the Board of Directors have an Audit and/or Finance Committee that convenes and communicates regularly with the treasurer and other Board members to assist in understanding and responding to financial developments (i.e., if adverse financial developments, are there systems in place that allow the organization to address them)?				
9. Does the person that authorizes payments of bills review original invoices and other support documentation?				
10. Are paid invoices cancelled?				
11. Is the person that approves invoices for payment someone other than the person requesting payment?				
12. Are amounts charged to the MDHHS Family Planning grant supported by approval invoices or other supporting documentation?				

13. Were all costs charged to the grant actually incurred during the grant period? (i.e., reported to the proper grant fiscal year?)				
14. Are record retention policies in place that comply with the program contract requirements?				
15. Are time/activity records maintained for employees working on more than one program, as well as personnel that work 100% in a particular program, so that only time actually worked on the program is allocated to the program?				
16. Do the personnel positions charged to the program conform to the positions and salaries authorized in the MDHHS Program Budget Summary?				
17. Are fringe benefits charged based on actual costs incurred, and supported by approved paid invoices?				

18. Are the fringe benefit costs charged to the program in relation to the salary costs allocated to the program?				
19. Does the agency have written travel policies and procedures defining reasonable limits for hotel and meal reimbursements, mileage rate(s), unallowable costs, and documentation requirements?				
20. Is travel charged to the MDHHS Family Planning grant supported by approved employee travel vouchers with appropriate receipts/documentation, and indicating the purpose of the travel?				
21. If space cost for agency owned buildings is charged to the grant, is the cost based on depreciation or use allowance, plus actual operating and maintenance cost?				
22. If space cost for rented building is charged to the grant, is the cost supported by a current signed lease agreement?				

23. Is space cost allocated to all programs that benefit from the space, based on square footage used, or other consistently applied allocation basis? (sometimes space cost is included as part of Indirect Cost.)				
24. Are costs for vendor contracts supported by a current signed contract?				
25. Are vendor contract charges supported by detailed billings as to type and amount of services/goods for the contract period and not just "for services rendered?"				
26. Are contract billings/reviewed to ensure consistency with the contract terms and objectives?				
27. Are indirect costs charged to the program? (e.g., agency-wide administration, division level administration, central service costs).				

28. Are indirect costs allocated to all programs that benefit from the overhead, by using a consistent basis? (e.g., based on a pro-rata share of personnel costs, or total direct costs of the programs that benefit.)				
29. Do the agency FSR's report total program costs?				
Cash Management:	**Yes/No/NA**	**Comments**	**Consultant Review/Observations** A/U	Comments
30. Does the agency have policies/procedures in place to assure timely submission of requests for reimbursement, documentation of financial status reports, and routing and filing of FSR's?				
31. Does the agency have procedures in place to ensure that costs for which reimbursement was requested were paid prior to the date of the FSR?				

Equipment:	Yes/No/NA	Comments	Consultant Review/Observations	
			A/U	Comments
32. If grant funds were used to purchase equipment, were the items purchased specifically approved by MDHHS in the original or amended budget and supported by approved invoices?				
33. Are inventory records maintained as well as aDNREuate safeguards over government-financed property and equipment including verification of equipment every two years, as required by 45 CFR 74.34? http://www.access.gpo.gov/nara/cfr/wisidx 03/45cfr7403.html				
34. Is the agency aware of Federal purchasing standards in 45CFR 74.44? http://www.access.gpo.gov/nara/cfr/waisidx 03/45cfr7403.html				
35. Does the agency have policies and procedures in place to ensure adherence with these standards?				

Program Income:	Yes/No/NA	Comments	Consultant Review/Observations	
			A/U	Comments
36. Is program income (fees and collections) billed on a sliding fee scale and does the fee scale conform to applicable poverty guidelines?				
37. Are duplicate receipt slips prepared for every receipt, and a copy given to the client, and does the receipt show full cost less any applicable discounts.				
38. Is all program income reported on the FSR?				
Reporting:	**Yes/No/NA**	**Comments**	**Consultant Review/Observations**	
			A/U	Comments
39. Are Financial Status Reports (FSRs) submitted timely?				
40. Do FSRs report actual cost, and not one-twelfth or one-quarter of the budget?				
41. Do FSRs report costs and revenues that follow the approved budget?				
			Consultant Review/Observations	

Sub-recipient Monitoring:	**Yes/No/NA**	**Comments**	A/U	Comments
42. Are sub-recipient activities supported by a current signed contract and budget for each Sub-recipient?				
43. Are the subcontract terms consistent with the MDHHS contract?				
44. Do sub-recipient FSRs or billings report actual cost and revenue and not one-twelfth or one-quarter of the budget?				
45. Are sub-recipient FSRs or billings submitted timely?				
46. Are sub-recipient FSRs or billings signed by a responsible official or the subcontractor?				
47. Are sub-recipient FSRs or billings reviewed by the agency for budgetary compliance and allowable costs before reimbursing the sub-recipient.				
48. Does the agency reimburse the sub-recipient on a timely basis? (e.g., within 30 days or other reasonable time of receipt of the billing.)				

49. Does the agency monitor the sub-recipients with on-site reviews.				
50. Does the agency monitor the sub-recipients with a financial checklist?				
51. Does the agency monitor the sub-recipients with any other checklists or procedures?				
52. Does the agency monitor sub-recipients to ensure individuals are given the opportunity to make voluntary contributions for services rendered, if applicable?				
53. Is program income reported by sub-recipients tested for accuracy and completeness?				
54. Does all applicable sub-recipient program cost and revenue get included in the agency's FSR to MDHHS?				
55. Does the agency communicate the following Federal program information to the sub-recipients: CFDA program title and number, source of funding, federal agency name, and OMB Circular A-133 audit requirements?				

56. Does the agency receive and review sub-recipient Single Audit Reports, if applicable?				
57. Does the agency issue management decisions on applicable subrecipient audit findings within six months after receipt of the sub-recipients audit report, and are corrective actions taken in a timely manner?				

Completed by: _____ Title: _____

MDHHS Consultant: _____ Date: _____

SECTION XII
Children's Special Health Care Services (CSHCS) Program

These advance materials must be sent directly to the CSHCS program:

1. Roster indicating the LHD CSHCS staff configuration (Indicator 1.1).
2. Dated correspondence that the staff roster was submitted to MDHHS initially and within required time frame following changes to staffing (Indicator 1.2).
3. Printed certificates of completed "What is Children's Special Health Care Services" on-line training including name and date (Indicator 1.3).
4. Dated notation in the employee's personnel record by the supervisor that the "LHD Orientation" on-line course has been taken (no printable certificate for this training) (Indicator 1.3).
5. Previous year's activities in client charts (individual clients will be specified by MDHHS) to provide physical evidence of comprehensive client records (Indicator 2.3)
6. Copy of signed and dated HIPAA agreements to comply form by each staff member (Indicator 2.4)
7. Written policies and procedures delineating the specified, required procedures (Indicator 3.2)
8. Copies of outreach to families e.g., family survey documents and results, satisfaction surveys, focus groups, meeting notes, etc. (Indicator 3.3)
9. Copies of agendas for meetings held with hospitals or other community agencies; sign-in sheets including title of meeting, location and date; copies of letter inviting/confirming attendance at community functions or meetings; and log sheet summarizing outreach efforts (Indicator 4.1)
10. Copies of all family correspondence and public relation materials (Indicator 4.4).
11. Care Coordination and Case Management logs for previous year's billings (if not previously submitted to MDHHS) (Indicator 6.7).

CSHCS MPRs and Indicators: What LHDs need to know for Cycle 6

Michigan Department of Health & Human Services Children's Special Health Care Services (CSHCS) program has revised the CSHCS Michigan Local Public Health Accreditation Program Minimum Program Requirements (MPRs) and Indicators for Cycle 6 of Accreditation.

Please be sure to review the 2015 MPR Tool for specific requirements.

This sheet is meant as a summary of the major changes to the Indicators and includes information the Accreditation Review Team will need for your visit.

Our goal is to be more transparent with the necessary information needed for review, and to improve the Accreditation program for you, as the LHD, and also for all of CSHCS and our families.

If you have any questions about the changes, please contact Courtney Pendleton at PendletonC@michigan.gov or 517/241-7189.

Please remember this document is meant for guidance regarding Accreditation. LHDs should consult the MPR Tool for all requirements.

MPR/ Indicator	Description of Change:	Additional Guidance:
1.1	Cycle 5 Indicators 1.1 & 1.2 have been combined. Indicator language has been clarified to demonstrate a staffing configuration that includes a Registered Nurse and a program representative is required. The staffing level per caseload graph listed within Indicator 1.1 is recommended.	Reviewers will need a staffing roster of all CSHCS staff, including their position (Rep, Nurse, etc.), county assignment (if applicable), CSHCS start date, and CSHCS end date (if applicable) for all staff working within CSHCS 1/1/12-today. Materials are required in advance of the onsite visit. Reviewers will be using "Contacts At A Glance," and FSRs for comparison purposes.
1.2	Cycle 5 Indicators 1.3 & 1.4 have been combined. Indicator language has been clarified to demonstrate that one person from each LHD is required to attend the annual regional meetings.	Certificates and/or personnel records are required for those employees starting within CSHCS as of 1/1/12-today, or when MDHHS CSHCS updates the trainings. Materials are required in advance of the onsite visit. MDHHS CSHCS has the original sign-in sheets for each regional LHD meeting, so it is not necessary for the LHD to submit verification, unless they neglected to sign-in.
2.1	Unchanged from Cycle 5	Reviewers will conduct an onsite review to ensure all staff listed on the "Contacts At A Glance", and FSRs have access and can efficiently use the CSHCS On-Line database.
2.2	Unchanged from Cycle 5	Reviewers will conduct an onsite review to ensure all staff listed on the "Contacts At A Glance", and FSRs have access and can efficiently use the EZ Link.
2.3	Unchanged from Cycle 5	Reviewers will be requesting up to 30 charts. The chart review will include **all** information/activities within the LHD charts from 1/1/12 to 12/31/14 (as if looking at a paper chart, for example). LHDs will be notified of the specific client chart list prior to the review. Materials are required in advance of the onsite visit.
2.4	Unchanged from Cycle 5	LHDs need to submit signed HIPAA agreements for all staff working within CSHCS starting 1/1/12-To Date. Materials are required in advance of the onsite visit.

MPR/ Indicator	Description of Change:	Additional Guidance:
2.5	Unchanged from Cycle 5	Reviewers will be asking to tour the LHD office, from the family's perspective.
3.1	Indicator language has been clarified to include the CSHCS Guidance Manual and the Medicaid Provider Manual.	LHDs need to be proficient in using both the CSHCS Guidance Manual and the Medicaid Provider Manual. Reviewers may ask for a demonstration of proficiency.
3.2	The specific, individual policy/procedure requirements have been moved to Addendum 1.	LHDs need to provide a signed statement(s), signed by managing/coordinating staff demonstrating CSHCS policies and procedures have been reviewed and updated annually for 2012, 2013, and 2014 (for 2015 visits). LHDs need to submit the 2014 policies/procedures. Materials are required in advance of the onsite visit. LHDs should only submit the 26 required elements.
3.3	Indicator language has been clarified regarding family input.	LHDs need to submit copies of family surveys, documents, satisfaction surveys, etc., and any follow-up information including results of the survey and any actions taken by the LHD; or other materials used for family input. Materials are required in advance of the onsite visit.
3.4	Unchanged from Cycle 5	Reviewers will be looking for the rights and responsibilities to be posted in all areas viewed by families; rights and responsibilities noted within the client charts; and/or copies provided to families.
3.5	Indicator language has been clarified to match the CPBC reporting requirements. It is important for all CSHCS to be aware of the CPBC reporting requirements.	MDHHS CSHCS will review the CPBC reporting requirements comparing it to the LHD submission information and dates. Reviewers will be verifying the CPBC required documentation and reports were received within the required timeframe.
4.1	Unchanged from Cycle 5	In order to better organize the various types of information gathered and submitted, our Accreditation Peer Nurse Reviewers have created an example of an outreach log that is available for use by all health departments (see Outreach Log attachment). LHDs need to submit copies of their outreach materials for activities performed 1/1/12-12/31/14 (for 2015

MPR/ Indicator	Description of Change:	Additional Guidance:
		visits). Materials are required in advance of the onsite visit.
4.2	Cycle 5 Indicators 4.2 & 5.4 have been combined. Indicator language has been clarified in regards to referrals and applications to other services and programs for CYSCHN and CSHCS clients.	Reviewers will be looking for chart documentation regarding referrals for the CSHCS-enrolled clients. During the onsite visit, Reviewers will be discussing with LHDs how they assist CYSHCN who are not enrolled in CSHCS.
4.3	Unchanged from Cycle 5	If Reviewers are unable to locate diagnostic evaluations within submitted chart documentation, copies of diagnostic evaluations will be requested at the onsite visit. LHDs should be prepared with copies of diagnostic evaluations authorized in 2012, 2013 and 2014.
4.4	Unchanged from Cycle 5	LHDs need to submit all LHD-created correspondence sent/given to families. Materials are required in advance of the onsite visit.
5.1	Unchanged from Cycle 5	Reviewers will be looking for application assistance within client chart documentation. If Reviewers are unable to locate application assistance within submitted chart documentation, copies of application assistance will be requested at the onsite visit.
5.2	Unchanged from Cycle 5	Reviewers will be looking for application follow-up within client chart documentation. If Reviewers are unable to locate application assistance within submitted chart documentation, copies of application follow-up will be requested at the onsite visit.
5.3	Unchanged from Cycle 5	Reviewers will be looking for follow-up regarding TEP within client chart documentation. If Reviewers are unable to location application assistance within submitted chart documentation, copies of TEP follow-up will be requested at the onsite visit.
6.1	Unchanged from Cycle 5	Reviewers will be looking for evidence of initial assistance and annual contact to clients/families

MPR/ Indicator	Description of Change:	Additional Guidance:
		within client chart documentation. If Reviewers are unable to locate initial and annual assistance within chart documentation, copies of application follow-up will be requested at the onsite visit.
6.2	Indicator language has been clarified to include various aspects of the CSHCS program and benefits available to families, including, but not limited to: billing problems, hospice, insurance issues, premium assistance, applications to the CSN Fund, applications for home care and/or respite services, TEFRA, etc.	Reviewers will be looking for assistance documented within the client charts.
6.3	Cycle 5 Indicator 6.4 is now Cycle 6 Indicator 6.3. Indicator language has been clarified to include youth, rather than 18 and 21 year olds.	Reviewers will be looking for assistance and activities documented within client charts regarding transition services.
6.4	Cycle 5 Indicators 6.5 and 6.6 regarding transportation have been combined. This indictor now discusses both in-state (IS) and out-of-state (OOS) transportation assistance.	Reviewers will be looking for documentation within client charts for both IS and OOS transportation assistance provided to families. If the LHD has not had any clients/families requesting OOS transportation during 1/1/12-12/31/14 (for 2015 visits), the LHD needs to be prepared to explain how assistance would be provided during the onsite visit.
6.5	Cycle 5 Indicator 6.67 is now Cycle 6 Indicator 6.6. Indicator language has been clarified to discuss OOS medical care assistance.	Reviewers will be looking for assistance provided to families requesting OOS medical care documented within client charts (assistance for OOS medical care is not the same as assistance for OOS transportation). If the LHD has not had any clients/families requesting OOS medical care during 1/1/12-12/31/14 (for 2015 visits), the LHD needs to be prepared to explain how assistance would be provided during the onsite visit.
6.6	Cycle 5 Indicator 6.7 is now Cycle 6 Indicator 6.6.	Reviewers will be comparing client chart documentation and previously submitted Care Coordination and Case Management logs.

Technical Contacts

Michigan Local Public Health Accreditation Program
Tool 2015
Users' Guide

	SECTION	NAME	TELEPHONE	EMAIL
I	LHD Powers & Duties	Mark Miller	517-335-8928 517-335-8032	Millerm1@michigan.gov
II	Food Service Program	Sean Dunleavy	517-243-8895	dunleavys@michigan.gov
III	General Communicable Disease Control	Shannon Andrews Johnson Tim Bolen Bethany Reimink Fatema Mamou Scott Schreiber	517-335-9597 989-832-6690 269-373-5293 616-632-7245 906-643-1100 x 208	johnson61@michigan.gov bolenT1@michigan.gov reiminkb@michigan.gov mamouf@michigan.gov schreibers@michigan.gov
IV	Hearing	Jennifer Dakers	517-335-8353	dakersj@michigan.gov
V	Immunization	Christopher Smith Barb Day	517-335-8333 734-240-7801	smithc63@michigan.gov dayb1@michigan.gov
VI	On-site Wastewater Treatment Management	Jeremy Hoeh	517-284-6528	hoehj@michigan.gov
VII	HIV/AIDs and Sexually Transmitted Disease	Bob Barrie	517-241-5934	barrier@michigan.gov
VIII	Vision	Rachel Schumann	517-335-6596	schumannr@michigan.gov
IX	Breast and Cervical Cancer Control Program	Tory Doney E.J. Siegl	517-335-8854 517-335-8814	doneyt@michigan.gov siegle@michigan.gov
X	Family Planning	Barbara Derman	517-335-8696	dermanb@michigan.gov
XI	Women, Infants, and Children (WIC)	Terri Riemenschneider Jean Egan	517-335-9562 517-241-6248	riemenschneidert@michigan.gov eganj@michigan.gov
XII	Children's Special Health Care Services (CSHCS)	Matt Richardson Courtney Adams	517-335-8994 517-241-7189	RichardsonM@michigan.gov AdamsC3@michigan.gov

Appendix I
Accreditation Review Evaluation *Cycle #6*

Local Health Department: _____ Date: _____

Section Evaluated: _____
Sections include: **I**=Local Health Department Powers and Duties, **II**=Clinical Laboratory **III**=Food Service Sanitation, **IV**=General Communicable Disease Control, **V**=Hearing, **VI**=Immunization, **VII**=On-Site Wastewater Treatment Management, **VIII**=Sexually Transmitted Disease, **IX**=Vision, **X**=Breast and Cervical Cancer Control Program, **XI**=Family Planning, **XII**=HIV/AIDS Prevention & Treatment

Number of Reviewers: _____ (just use one evaluation form for all reviewers in this section)

Directions: Circle the number that corresponds to your response, using the following scale: 1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree NA = Does not apply or leave blank if you prefer not to answer	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. Technical assistance was offered to LHD prior to On-site Review and met need	1	2	3	4	5	NA
2. A clear overview of "what will occur" and "how the LHD will be evaluated" was provided by the reviewer(s) either on-site or in advance of the visit.	1	2	3	4	5	NA
3. Reviewer(s) conduct was professional throughout visit.	1	2	3	4	5	NA
4. The reviewer(s) maintained a quality improvement focus.	1	2	3	4	5	NA
5. The reviewer(s) are knowledgeable on the subject of their section.	1	2	3	4	5	NA
6. The reviewer(s) made judgments consistent with the current Accreditation tool.	1	2	3	4	5	NA
7. The reviewer(s) allowed for an appropriate amount of interaction.	1	2	3	4	5	NA
8. The reviewer(s) listened carefully to LHD responses to questions.	1	2	3	4	5	NA
9. Reviewer(s) conducted an exit interview (if no or not requested, skip 10- 13)	No			Yes		
10. Program strengths and weakness were discussed.	1	2	3	4	5	NA
11. Recommendations for improvement were made as necessary.	1	2	3	4	5	NA
12. The written On-site Review Report made use of the "Special Recognition" and "Recommendations for Improvement" categories.	1	2	3	4	5	NA

13. The On-site Review Report provided for this section is very helpful to use to improve the quality of this program.	1	2	3	4	5	NA
14. Overall, the reviewer(s) did an excellent job.	1	2	3	4	5	NA
15. The review findings were compatible with my agency's self assessment.	1	2	3	4	5	NA

1. List the strong points of the review:
   _____
   _____
   _____
2. List areas of the review in need of improvement:
   _____
   _____
   _____
3. Who may we contact for additional information?
   _____
   _____

Note: if you would like to be contacted, please include name and telephone number below.
Survey Respondent Name: _____
Telephone: ( ) _____

Return within 30 days from notification of On-site Review Report completion to:
Michigan Association for Local Public Health (MALPH)
P.O. Box 13276
Lansing, MI 48901

Appendix II
Corrective Plan of Action Form

Local Health Departments must submit Corrective Plan(s) of Action (CPAs) to the Michigan Local Public Health Accreditation Program within 60 days of the last day of local health department's On-site Review. Please note that the following form is for reference only; all CPAs must be submitted via the web-based reporting module.

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 clicking the "Publish" button.

Date: 5/20/2015
Local Health Dept Name: Demo Health Department
Your Name:
Title:

Local Health Department Staff Responsible for Implementing Corrective Plan of Action

Name:
Title:
Phone:
Fax:

Indicator Not Met: Vision - Minimum Program Requirement #1, Indicator 1.1
Indicator Description: There is a system in place to schedule children between the ages of 3 and 5 years for vision screening upon request.

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:

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.

Save Return to CPA Page