Table of Contents

Section I: Powers and Duties

MPR 1

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

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

Indicator 1.1

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Question:

None.

Indicator 1.2

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

This indicator may be met by:

- Demonstrating access to vital and health statistics for both intern and external customers.
- Documents that demonstrate both qualitative and quantitative analysis and interpretation of vital and health statistics in reports for, at a minimum, the major causes of morbidity, mortality and environmental health hazards within the jurisdiction.

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

None.

Indicator 1.3

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

None.

Indicator 1.4

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

None.

Section I: Powers and Duties

Indicator 1.5

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

None.

Indicator 1.6

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

This indicator may be met by:

A current Plan of Organization adopted by the local governing entity and approved by the Director of the Michigan Department of Health & Human Services (MDHHS), containing an organizational chart which includes the names of all local health department leadership, must be on file with MDHHS at all times.

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

Did the local health department maintain continuity of operations during the entire accreditation cycle with both a Health Officer and Medical Director in good standing per the Michigan Public Health Code and Michigan Administrative Code?

Indicator 1.7

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

This indicator may be met by:

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

Section I: Powers and Duties

Documentation Required:

See the 'This indicator may be met by:' section of this indicator.

Evaluation Question:

None.

Indicator 1.8 (Not Scored; Demonstration Population Health 3.0 Indicator for Cycle 7)

A local health department may take on a role as the "Chief Community Health Convener". This role involves the health department leading their community's health promotion efforts in partnership with stakeholders with a direct or indirect interest in improving the population's health and leaders in widely diverse sectors including, but not limited to: social services, environmental health, education, transportation, public safety, and community economic development. Emphasis is placed on catalyzing and taking actions that improve the community's well-being. (Section 2433).

This indicator may be met by:

1) Documentation that the local health department has developed at least one (1) initiative focused on convening meetings with clinical providers and insurers to develop linkages between population health and clinical care in its jurisdiction; or

2) Documentation that the local health department has developed at least one (1) initiative focused on collaboration with community partners that have the potential to make a positive impact on the living conditions of the more vulnerable segments of the community.

Documentation Required:
See the 'This indicator may be met by:' section of this indicator.

Evaluation Questions:

1) Has the local health department convened at least one meeting between the aforementioned sectors for either of the projects?
2) Were future objectives and action items identified during the completion of the project?
3) Were there subsequent meetings, discussions, or correspondence that led toward to completion of the aforementioned objectives and action items?
4) Were any of the objectives or action items not completed? If so, please explain the circumstances.
5) Did the project clearly define the linkages between population health and clinical care in Option 1 or the threshold for a positive impact on the living conditions of the more vulnerable segments referenced in Option 2?
6) If Option 2 was selected, did the project clearly define the processes used to identify the more vulnerable segments of the community?

Section I: Powers and Duties

Attachment A

MATRIX OF SERVICES OF LOCAL PUBLIC HEALTH

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

Section I: Powers and Duties

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

Section I: Powers and Duties

MATRIX DEFINITIONS

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

Attachment B

LAWS APPLICABLE TO LOCAL PUBLIC HEALTH (LPH)

Public Health Code (PA 368 of 1978)

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

Appropriations (Current: PA 349 of 2004)

Sec. 218 – Basic Services
Sec. 904 - LPHO

Michigan Attorney General Opinions

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

Food Law of 2000 (PA 92 of 2000)

MCL §§ 289.1101 *et seq.*
Specifically:
MCL § 289.1109 – Definition of local health department
MCL § 289.3105 – Enforcement, Delegation to local health department

Section I: Powers and Duties

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

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

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

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

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

Attachment C

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

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

Sec. 2475.

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

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

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

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

MPR 1

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

Reference: *PHAB Standards and Measures 1.5, Standard 9.1*

Indicator 1.1

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

This indicator may be met by:

- Agency leadership and management are supportive of and engaged in establishing and/or updating a performance management system.
- Agency staff at all other levels are engaged in establishing and/or updating a performance management system.

Documentation Required:

- 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.

Evaluation Questions:

- How have leadership and staff been engaged in developing your agency's performance management system?
- How have leadership and staff been engaged in using and updating your agency's performance management system?
- How has the agency engaged their local governing entity regarding the establishment of the performance management system?

Indicator 1.2

The agency has adopted a department-wide performance management system.[1]

This indicator may be met by:

- The agency has adopted a performance management system.

Documentation Required:

- A written description of the department's adopted performance management system that includes:
    a. Performance standards, including goals, targets, and indicators, and the communication of expectations.
    b. Performance measurement, including data systems and collection.
    c. Progress reporting including analysis of data, communication of analysis results, and a regular reporting cycle.

[1] Or is in the process of adopting a department-wide performance management system.

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

d. A process to use data analysis and manage change for quality improvement (QI) toward creating a learning organization.

Evaluation Questions:

- How does the adopted performance management system use objectives and measurement to evaluate performance of programs, policies, and processes, and achievement of outcome targets?
- How does the agency use the performance management system to ensure that goals are being met consistently in an effective and efficient manner?
- How does the agency use the performance management system to identify needed improvements?

Indicator 1.3

The agency has implemented a performance management system.[2]

This indicator may be met by:

- The agency has a functioning performance management committee or team that is responsible for implementing the performance management system.
- The agency has established goals and objectives with identified time frames for measurement across programs and functions.
- The agency has implemented a process for monitoring the performance toward set goals and objectives.
- The agency analyzes progress toward achieving goals and objectives, and identifies areas in need of focused improvement processes.
- Through analysis of collected data, the agency identifies results and identifies next steps.
- The agency has completed a performance management self-assessment.

Documentation Required:

- 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.[3]

Evaluation Questions:

- What process did the agency use to identify and set goals for performance?
- What is the ongoing process the agency uses to measure progress toward goals for performance?
- What is the process for reporting progress toward goals for performance?
- How does the agency use data to identify and address opportunities for improvement?

[2] Or has plans for implementing a performance management system that incorporates the stated requirements.
[3] For example, the Public Health Foundation's Public Health Performance Management Self-Assessment or the self-assessment tools available through the Baldrige Performance Excellence Program.

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

Indicator 1.4

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

This indicator may be met by:

- The agency has collected, analyzed, and made conclusions from feedback from at least two different customer groups.
- The agency has taken actions based on customer feedback.

Documentation Required:

- 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.

Evaluation Questions:

- Describe the agency's process for collecting customer feedback
    - How does the agency collect customer satisfaction data?
    - How does the agency analyze customer satisfaction data?
    - How is feedback shared with staff?
    - How does the agency use customer satisfaction data for process and/or program improvement?
- How does this process work across the agency?

Indicator 1.5

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

This indicator may be met by:

- The agency has provided staff development opportunities related to performance management.

Documentation Required:

- Documentation of agency staff participation in performance management training.

Evaluation Questions:

- How does the agency ensure staff competence in the appropriate use of tools and techniques for monitoring and analyzing objectives and indicators as part of the performance management system?

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

MPR 2

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

Reference: *PHAB Standards and Measures 1.5, Standard 9.2*

Indicator 2.1

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

This indicator may be met by:

- Establishment and implementation of an agency QI Plan.
- The QI plan is aligned with the agency's identified priorities and incorporated into its performance management system.
- The QI plan has been shared with agency staff.

Documentation Required:

- 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

Evaluation Questions:

- What was the process used to develop the QI Plan?
- How is the QI Plan aligned with the department's strategic direction and performance management system?
- How do staff learn about the department's QI Plan?
- How has the agency implemented the QI Plan?

Indicator 2.2

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

This indicator may be met by:

Agency engagement with local governing entity to establish QI policies and direction for implementation.

Documentation Required:

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

Evaluation Questions:

- How does the agency engage the local governing entity regarding the establishment of organizational QI polices and direction?
- How does the agency keep QI visible and ongoing?

Indicator 2.3

The agency has implemented QI activities.

This indicator may be met by:

- The agency has engaged in QI activities based on the QI Plan.
- Agency staff participate in QI activities based on the QI Plan.

Documentation Required:

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

Evaluation Questions:

- How has the agency used findings from the performance management system to establish process or program improvements?
- What QI activities has the agency implemented?
- What QI method(s) does the agency use to address identified issues and improve programs?
- How does the agency assure that improvement is ongoing?
- How are employees included in QI activities?

Indicator 2.4

Assure QI training and technical assistance are available to staff.

This indicator may be met by:

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

Documentation Required:

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

Evaluation Questions:

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

Section II: Food Service

MPR 1
Plan Review

Materials necessary for auditing the MPR

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

Sample Selection:

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

Program Indicators:

- Does the department review complete sets of plans and specifications?
  a. Application form/transmittal letter summarizing scope of plans or project (FL 6105)
  b. Completed worksheet
  c. Menu
  d. Standard Operating Procedures (SOP)*
  e. Layout (plans), including scaled drawings**
  f. Equipment specifications or equivalent information such as make and model number
  g. A copy of the pre-opening evaluation report is in the file
  h. The evaluation report has a notation which indicates the establishment is approved to operate
  i. The evaluation report verifies that there were no Priority, or no more than two Priority, foundation violations present prior to opening
  j. Use of plan reviewer's checklist
  k. Calculations to show what is needed and what is proposed for hot water, dry storage, and refrigerated storage for all establishments, including documentation of approval for less than the required calculations, engineering documentation, or other justification for approval
  l. Applicant is informed in writing of any deficiencies - All identified deficiencies are addressed in writing, email, a documented phone call, or on revised plans
  m. Plan approval letter is in the file that includes reference to a unique identifier (i.e. date, location address, specified code number) marked on the approved plans and specifications - See MDARD "Model Plan Review Approval" letter for an example

Section II: Food Service

(Note: Scope of project should be on the application/transmittal letter but may be found elsewhere in the plan review paperwork.)

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

OR

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

OR

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

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

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

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

How to judge compliance with MPR 1

- **Met** – 80% of the establishment files evaluated indicate that the department reviews complete sets of plans and properly documents the plan review process.
- **Not Met** – Overall, less than 80% of the evaluated files meet the indicators; the plan review process does not assure complete sets of plans and the plan review processes are poorly documented (give specific examples and percentages).

Tips for passing MPR 1

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

Section II: Food Service

MPR 2
Evaluation Frequency

Materials necessary for auditing the MPR

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

Sample Selection

- This sample of fixed food service establishments is used to evaluate MPRs 2, 4, 5, 6, 7, and 8.
- Use "Annex 6 - Office Sample Size Chart" and "Annex 5 - Approved Random Sampling Methods" guide to determine the number of establishments for review.
- Where there are multiple offices, a proportional sample should be selected to reflect the percentage of establishments regulated by each individual office (i.e. 35% of the establishments are located in County A and 65% are in County B).
- If possible, make certain the total sample size includes at least one (1) mobile food service establishment, and one (1) special transitory food unit (STFU) file.
- Obtain the folder for each of the establishments in the sample.

Program Indicators

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

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

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

       Example folder for Bill's Burgers
       Accreditation period: February 10, 2003 – February 10, 2006
       First Evaluation: April 20, 2003
       Next routine: November 15, 2003 (ok < 7 months from last evaluation)

Section II: Food Service

Next routine: May 10, 2004
Next routine Missed – no evaluations
Next routine: April 30, 2005
Next routine: November 13, 2005 (ok < 7 months from last evaluation)
Number of required Evaluations = 6
Number of evaluations conducted at proper frequency = 5
Percentage of evaluations = 83%

b. Seasonal Fixed Establishments: Determine if one evaluation was made during each operating season in the review period. (NOTE: Seasonal establishments under the Food Law, are required to have one inspection which can be done any time throughout the operating season. A seasonal fixed operation that is established under an RBE schedule to be evaluated every 12 months may show a frequency of every 12 months, but must minimally show an evaluation at least once in operating period.) Determine the percentage of evaluations that were made at the required interval for each establishment.

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

1. **How to judge compliance with MPR 2**
   - Evaluation frequency based upon Food Law, Section 3123.
   - An individual establishment will be considered to meet evaluation frequency when 80% of the required routine evaluations have been made (i.e. six evaluations required; five evaluations conducted).
   - **Met** – 80% of the establishments in the sample meet evaluation frequency (i.e. if there are 22 establishments in a sample, 18 establishments are required to meet evaluation frequency).
   - **Met with Conditions** – Less than 80% of the establishments in the sample meet evaluation frequency; however, at least 80% of the total number of evaluations required for all of the establishments in the sample have been conducted. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator at the next evaluation will result in a "Not Met."
   - **Not Met** – Less than 80% of the establishments meet evaluation frequency requirements. Less than 80% of the total number of evaluations required for all of the establishments in the sample have been conducted.

Section II: Food Service

EVALUATION FREQUENCY USING A RISKED BASED EVALUATION SCHEDULE

A local health department may utilize an optional Michigan Department of Agriculture and Rural Development (MDARD) "Risk Based Evaluation Schedule." For those agencies, evaluation frequencies will be audited utilizing that schedule. See Risked Based Evaluation Schedule, MDARD memo dated November 13, 2008.

Tips for Passing MPR 2

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

Section II: Food Service

MPR 3

Temporary Food Service Establishment Evaluations

Materials necessary for auditing the MPR

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

Sample Selection

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

Program Indicators

- Determine if the local health department has conducted an operational evaluation OR office consultation, for low risk establishments only, of each temporary food service establishment prior to licensure.
- Determine if the temporary food establishment application sections of page one: Applicant/Business Contact Information, Public Event Information, and the Food column of the table on page two are completed. Determine if all fields of the license form have been completed with the evaluation date, the date the license was approved, and the sanitarian's signature. Determine if Appendix A of the application form when used has been completed.
- Determine if a temporary food service license was issued with uncorrected Priority or more than two uncorrected Priority Foundation violations.

Note: As stated in FL section 3115(3): "If a temporary food establishment (TFE) will serve only low-risk food, instead of conduction of an inspection under subsection (2), a LHD, based on a public health risk assessment, may conduct an in-office consultation, including food safety education, and operational review of the proposed temporary food establishment with the license applicant. The person in charge of the TFE must be present during the in-office consultation."

A notation on the Temporary Food License that an office consultation was conducted or other similar documentation will meet this indicator.

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

Section II: Food Service

How to judge compliance with MPR 3

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

Tips for passing MPR 3

- Conduct an operational evaluation of all temporary food service establishments prior to licensure.
- Use the MDARD "Food Service Establishment Evaluation Report," form (FI-214).
- Review the application, license, and evaluation reports to make certain they are complete and accurate.
- Do not make notes on evaluation reports that resemble violations (i.e. hold all cold foods at 41°F and below). Use "Fact Sheets," "Temporary Food Establishment Operations Checklist," etc. to convey educational information.
- All Priority or Priority Foundation violations must be corrected before issuing a Temporary Food Establishment License.
- Conduct quality assurance reviews of the completed licenses and evaluation.

Section II: Food Service

MPR 4
Evaluation Procedures

Materials necessary for auditing the MPR

- The materials and sample used to evaluate MPRs 2 and 3 are used to evaluate MPR 4.

Program Indicators

- Determine if the local health department uses an evaluation report form approved by MDARD.
- Administrative information about the establishment's legal identity, address, and other information is entered on the evaluation report form.
- The report findings properly document and identify Priority, Priority Foundation, and Core violations.
- The evaluation report summarizes the findings relative to compliance with the law.
- The report is legible.
- The report conveys a clear message.
- The narrative clearly states the violations observed and necessary corrections.
- Timeframes for correcting Priority, Priority Foundation, and Core violations are specified.
- The evaluation report is signed and dated by the sanitarian.
- The evaluation report is signed by an establishment representative.

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

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

How to judge compliance with MPR 4

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

Tips for passing MPR 4

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

Section II: Food Service

MPR 5
Demonstration of Staff Field Review

Materials necessary for auditing the MPR

# inspectors per agency	Establishments visited per agency
1-2	Minimum of 2 inspections
3-6	4 inspections
7+	75% of inspectors, max of 12 inspections

- Show demonstration of risk-based evaluations by a variety of program staff, when possible, each establishment visit must be with a different inspector. A maximum of one standardized trainer who is currently conducting routine inspections may be used.
- A list of all staff doing routine inspections shall be provided to MDARD prior to the audit. The list of inspectors going out with MDARD will be provided to the local health department on the Friday prior to the audit. MDARD will use a random number generator to choose the inspectors being evaluated, and MDARD will also chose the establishments by random numbers. Only high risk facilities (Z) will be chosen for this review.
- Demonstrate that Risk Factors and Good Retail Practices in the establishments are correctly identified and resolved. MDARD will use the Accreditation MPR 5 Field Worksheet for scoring the inspections.

How to judge compliance with MPR 5

- **Met** – 80-100% department compliance with risk based evaluation methodology.
- **Met with Conditions** – 70-79% department compliance with risk-based evaluation methodology.
- **Not Met** – Less than 70% department compliance with risk-based evaluation methodology.

Tips for passing MPR 5

- Make certain staff is appropriately trained to conduct risk-based evaluations.
- Have inspectors document observed violations, whether corrected at time of evaluation or not.
- Conduct internal quality assurance audits to make certain that staff is properly identifying intervention and risk factor violations and good retail practice violations.
- Utilize the Accreditation MPR 5 Field Worksheet or similar document when training and/or evaluating food service inspection staff.

Section II: Food Service

MPR 6
Records

Materials necessary for auditing the MPR/Sample Selection

- The materials and sample used to evaluate MPRs 1, 3, 4, 9, and 10 are used to evaluate MPR 6.

Program Indicators

- Records are maintained in accordance with "Annex 3 – Excerpt from MDCH General Schedule #7."
- The local health department staff can retrieve the records necessary for the audit.
- Applications and licenses are processed in accordance with law. Complete application information includes:
  a. The date of issuance
  b. The date(s) of operational inspections for STFUs
  c. Signatures (approved electronic signatures are acceptable) of the operator and signature of a person designated by the department and/or their assignees are provided
  d. Pre-opening evaluation report is dated either before, or on the same day the license is signed

How to judge compliance with MPR 6

- **Met** – 80% of overall records are in compliance.
- **Met with Conditions** - 70-79% of compliance overall record keeping.
- **Not Met** – Less than 70% of compliance in record keeping.

Tips for passing MPR 6

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

Section II: Food Service

MPR 7
Enforcement

Materials necessary for auditing the MPR

- Copy of the local health department's enforcement policy.
- The records and sample used to evaluate MPR 4.

Program Indicators

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

How to judge compliance with MPR 7

- **Met** – At least 80% of the establishment folders reviewed indicate the enforcement policy is being followed. An enforcement policy that meets the evaluation criteria has been adopted.
- **Met with Conditions** – An enforcement policy that meets the evaluation criteria has been adopted. At least 80% of the establishment folders indicate the enforcement policy is being followed; however, there is at least one example of a significant lack of enforcement action that could have public health consequences. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator at the next evaluation will result in a "Not Met."
- **Not Met** – Less than 80% of the establishment folders indicate the enforcement policy is being followed. An enforcement policy that meets the evaluation criteria has not been adopted.

Tips for passing MPR 7

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

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

Section II: Food Service

MPR 8
Follow-up Evaluation

Materials necessary for auditing the MPR/ sample selection

- The materials and samples used to evaluate MPR 4 are used to evaluate this MPR.

Program Indicator

- A follow-up evaluation shall be conducted by a local health department, preferably within 10 calendar days, but no later than 30 calendar days, to confirm correction of all previously identified Priority and Priority Foundation violations
- Information about the corrective action is described on the evaluation report. This includes violations that are corrected at the time of evaluation. For evaluations that do not require an onsite follow-up review, see MDARD memo dated 2-19-10
- A separate report form is used to record the results of the follow-up evaluation.
- An individual establishment will be considered to meet the standard when 80% of the follow-up evaluations are conducted within 30 calendar days.
- If not more than 2 Priority Foundation item violations are noted and the director determines that the violations are not a risk to food safety, the director may confirm correction of the priority foundation item violations at the next routine evaluation.

How to judge compliance with MPR 8.

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

Tips for passing MPR 8

- Create a tracking system to assure that follow-up evaluations are conducted.
- Do not write phrases on the report such as "OK" and "Corrected" at time of evaluation for Priority and Priority foundation violations.
- Document the specific action that has been taken to correct the Priority or Priority foundation violations.

Section II: Food Service

MPR 9
License Limitations

Materials necessary for auditing the MPR

- Local health department policy manual
- Local health department list of establishments having licenses limited during the Accreditation Review period

Sample Selection

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

Program Indicators

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

How to judge compliance with MPR 9

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

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

Tips for passing MPR 9

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

Section II: Food Service

MPR 10
Variances

Materials necessary for auditing the MPR

- Local health department policy manual
- Local health department list of variances evaluated during the Accreditation Review period

Sample Selection

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

Program Indicators

- Determine if variances are required for specialized processing methods as required by Section 3-502.11 of the Food Code.
- Determine if the applicant's variance request is maintained in the file.
- Determine if the applicant has provided a statement of the proposed variance of the Food Code citing relevant code section numbers, an analysis of the rationale for how the public health hazards addressed by relevant code sections will be alternately addressed by the proposal, and a Hazard Analysis Critical Control Point (HACCP) plan if required (FC sections 8-103.11).
- Determine if staff is following the department's procedures.

How to judge compliance with MPR 10

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

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

Tips for passing MPR 10

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

Section II: Food Service

MPR 11

Consumer Complaint Investigation (Non-foodborne Illness)

Materials necessary for auditing the MPR

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

Sample Selection

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

Program Indicators

- Determine if a consumer complaint tracking system has been created.
- Determine if consumer complaint investigations are initiated within 5 working days.
- Determine if the findings (a brief notation that explains the results and conclusions of the investigation) are noted either in the logbook or on the filed complaint record.

How to Judge Compliance with MPR 11

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

Section II: Food Service

MPR 12

Staff Training and Qualifications - Technical Training

Materials Necessary for Auditing the MPR

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

Sample Selection

- The training record for each employee is reviewed.

Program Indicator

- Determine if the training record indicates each individual has completed training in the six designated skill areas:
  a. Public health principles
  b. Communication skills
  c. Microbiology
  d. Epidemiology
  e. Food Law, Food Code, related policies
  f. HACCP (must complete training within 12 months of being assigned to the program. Employees that are not fully assigned to the food program or part time employees have 18 months to complete training.)
- The local health department's judgment as to the completeness and complexity of the training for each skill area must be documented.
- Documentation of previous training or evaluations performed under a training plan by the Director of a new sanitarian that has completed training at another local health department or has similar experience.

Note: Employees only involved in the evaluation of specialty food service establishments are not included in the evaluation for MPR 12.

How to Judge Compliance with MPR 12

- **Met** – The training record for each employee indicates that training has been completed in the six designated skill areas within 12 months from the date of being assigned to the program. Employees that are not fully assigned to the food program or part time employees have completed training in18 months.
- **Met with Conditions** - The training record for each employee indicates that training has been completed in the six designated skill areas, but the training period exceeded 12 months for full time employees or 18 months for the employees that are not fully assigned to the food program. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator at the next evaluation will result in a "Not Met."
- **Not Met** – Either training records are not maintained or the records indicate that training has not been completed in the six designated skill areas.

Section II: Food Service

Tips for Passing MPR 12

- Completion of recommended ORA University (ORAU) curriculum or equivalent courses.
- To assess the technical training of a newly hired / newly assigned food inspector, use the Technical Training section of the MDARD: FOOD PROGRAM TRAINING NEWLY HIRED / NEWLY ASSIGNED FOOD PROGRAM INSPECTORS (Can be found in Resources for Regulators / Training http://www.michigan.gov/mdard/0,4610,7-125-50772_50775_51204---,00.html)
- To assess the technical training of a Previously Trained / Experienced Inspector, use the Technical Training Requirements section of the MDARD: FOOD PROGRAM TRAINING - Assessing the Risk Based Inspection Skills of a Previously Trained / Experienced Inspector (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mdard/0,4610,7-125-50772_50775_51204---,00.html)

Section II: Food Service

MPR 13

Fixed Food Service Evaluation Skills

Materials Necessary for Auditing the MPR

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

Sample Selection

- The training record for each employee is reviewed.

Program Indicator

- Determine if the training record indicates 25 joint evaluations, 25 independent evaluations under the review of the trainer (either on-site or paperwork review), and five evaluation inspections have been conducted with the standardized trainer within 12 months of employment or assignment to the food program. Employees that are not fully assigned to the food program or part time employees have 18 months to complete training. Employees only involved in the evaluation of specialty food service establishments are exempt.
- Documentation of previous training or evaluations performed under a training plan by the Director of a new sanitarian that has completed training at another local health department or has similar experience.

How to Judge Compliance with MPR 13

- **Met** - The training record for each employee with no previous applicable experience indicates 25 joint evaluations with the standardized trainer, 25 independent evaluations under the review of the standardized trainer, and five evaluation inspections have been conducted with the standardized trainer within 12 months of employment or assignment to the food program. Employees not fully assigned to the food program have completed the training in 18 months.
- **Met with Conditions** – The training record for each employee indicates 25 joint evaluations, 25 independent evaluations under the review of the trainer, and five evaluation inspections have been conducted with the standardized trainer, but there is evidence that independent evaluations were being conducted prior to the completion of training. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure at the next evaluation to meet this indicator will result in a "Not Met".
- **Not Met** – Either training records are not maintained or the records indicate 25 joint evaluations, 25 independent evaluations, and five evaluation inspections have not been completed within 12 months of employment or assignment to the food program, and the employee is conducting independent evaluations. For employees not fully assigned to the food program, training was not completed within 18 months of employment or assignment to the food program, and the employee is conducting independent evaluations.

Section II: Food Service

Tips for Meeting MPR 13

- A training assessment is recommended for a sanitarian new to a department who has become qualified and experienced while working in another local health department. The assessment should consist of a document review of the inspector's credentials as well as a field skill review. A training plan should be developed based on the review. To assess the training of a newly hired / newly assigned food inspector, use the Fixed Food Service Evaluation Skills Training section of the MDARD: FOOD PROGRAM TRAINING - NEWLY HIRED / NEWLY ASSIGNED FOOD PROGRAM INSPECTORS: (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mdard/0,4610,7-125-50772_50775_51204---,00.html)
- To assess training of a Previously Trained / Experienced Inspector, use the Fixed Food Service Evaluation Skills Training Requirements section of the MDARD: FOOD PROGRAM TRAINING - Assessing the Risk Based Inspection Skills of a Previously Trained / Experienced Inspector: (Can be found in Resources for Regulators / Training / http://www.michigan.gov/mdard/0,4610,7-125-50772_50775_51204---,00.html)

Section II: Food Service

MPR 14

Specialty Food Service Evaluation Skills

Materials Necessary for Auditing the MPR

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

Sample Selection

- Supervisor endorsement for each employee is reviewed.

Program Indicators

- Determine if the supervisor has endorsed all employees who evaluate specialty food service establishments (mobile, STFU, temporary) as having knowledge of the Food Law, Food Code, public health principles, and communication skills. Each employee must be endorsed for each type of specialty food service facility they evaluate. Automatic endorsement is received when an employee has met the requirements of MPR 12 and 13.

How to Judge Compliance with MPR 14

- **Met** – Supervisor endorsement for each newly assigned employee involved in the evaluation of specialty food service establishments is completed before conducting independent evaluations. OR the employee has met the requirements of MPR 12 and 13.
- **Met with Conditions** - The supervisor endorsement for each newly assigned employee involved in the evaluation of specialty food service establishments is completed, but a newly assigned employee conducted independent evaluations prior to supervisor endorsement. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator at the next evaluation will result in a "Not Met."
- **Not Met** – Supervisor did not evaluate and endorse a newly assigned inspector before conducting independent evaluations for each type of assigned establishment.

Tips for meeting MPR 14

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

Section II: Food Service

MPR 15

Foodborne Illness Investigations- Timely Response

Materials Necessary for Auditing the MPR

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

Sample

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

Program Indicators

- Determine if foodborne illness complaint investigations are initiated within 24 hours. "Initiated" includes the initial contact, phone calls, file reviews, etc., made by the person responsible for conducting the investigation.
- Determine if the LHD has promptly reported potential foodborne outbreaks to MDARD by forwarding information required on the Form 'A" intake. (Pursuant to FL section 3129 (1))
- Determine if the LHD immediately notified MDARD when their investigation indicated that a source of a foodborne disease or poisoning was from an MDARD licensed Food Establishment by sending an FI-238. (Pursuant to FL section 3129(2))
- Determine if the local health department has submitted a copy of the final written report to the MDARD within 90 days after the investigation has been completed.

How to Evaluate Compliance with MPR 15

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

Section II: Food Service

MPR 16

Foodborne Illness Investigation Procedures

Materials Necessary for Auditing the MPR

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

Sample

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

Program Indicators

- Determine if the complaint log or tracking system is systematically reviewed each time a FBI complaint is received to determine if isolated complaints may indicate the occurrence of a foodborne illness outbreak.
- Determine if documentation of the date of the log review and who conducted the review is on the complaint intake form A or in the complaint database.
- Determine if the department has and follows standard operating procedures for foodborne disease surveillance and investigating foodborne illness outbreaks that include:
  a. A description of the foodborne illness investigation team and the duties of each member.
  b. Identify who will review log or tracking system for trends and how the reviews will be documented.
  c. Outline the methods used to communicate foodborne illness as stated in the Food Law 3131.(1) "A local health department shall develop and implement a communications system with other applicable governmental agencies, individuals, and organizations including, but not limited to, hospital emergency rooms and state and local police. The communications system shall provide the means to contact specific local health department employees and basic information necessary to initiate a foodborne illness outbreak investigation. The information provided in the communications system shall be updated annually."

- Determine if department uses the proper forms for investigating foodborne illness complaints.
  a. For all alleged FBI complaints a Form A or equivalent, and
  b. any of the following documents:
     (1) LHD Electronic database form
     (2) IAFP form C1/C2 OR equivalent
     (3) The Michigan Gastrointestinal Illness Complaint Interview Form
     (4) MDSS interview form or;
     (5) An outbreak-specific questionnaire (if one is used)

- Determine that copies of completed forms are available for review during the audit, may be electronic.
- Determine if the department uses procedures consistent with those described in the International Association for Food Protection publication "Procedures to Investigate a Foodborne Illness, 5th edition" or as contained in section 3131(2) of the Michigan Food Law.

Note: Documentation of notification to other State or Local agencies is completed on Form A or other effective means as stated in MPR 15.

How to Evaluate Compliance with MPR 16

- **Met** – Standard operating procedures that meet MPR 16 are in place and are followed.
- **Met with Conditions** – Overall the department has and follows standard operating procedures that meet MPR16, however, some minor exceptions need to be addressed. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator at the next evaluation will result in a "Not Met."
- **Not Met** – Written operating procedures that meet MPR 16 have not been provided and/or the procedures outlined in MPR 16 for investigating foodborne illness outbreaks are not being followed.

Tips for Passing MPR 15 and 16

- Staff conducting foodborne illness investigations should periodically review "Procedures to Investigate Foodborne Illness, 5th edition" or as contained in section 3131(2) of the Michigan Food Law.
- Assemble the foodborne illness investigation team at least once annually to review procedures.
- Contact local governmental agencies and organizations at least annually to review foodborne illness reporting and investigation responsibilities. Be certain to include local hospitals and the medical community in the policy.

Section II: Food Service

Important Factor 1
Industry and Community Relations (Equivalent to FDA Retail Standard 7)

Important Factor 1a - Industry Education Outreach

Materials Necessary for Auditing Important Factor 1a

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

How to Evaluate Compliance with Important Factor 1a

Met –Agency participation in at least one activity listed under the program indicator (educational outreach) annually is sufficient to meet this standard.

Tips for meeting important factor 1a

- Place food safety information on the department's website.
- Food safety training provided to the industry

OR

Important Factor 1b - Community Relations

Materials Necessary for Auditing Important Factor 1b

- Documentation to provide evidence of annual surveys or meetings held with industry and community for the purpose of soliciting food service program related recommendations and feedback

Program Indicators

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

Section II: Food Service

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

How to Evaluate Compliance with Important Factor Ib

- **Met** –Agency participation in at least one activity listed under the program indicator section for Important Factor 1b (industry and community relations) annually is sufficient to meet this standard.

Tips for meeting Important Factor 1b

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

Note: Special comments will be added if a LHD meets both Important Factor 1a and 1b.

Section II: Food Service

Important Factor II
Continuing Education and Training

Materials Necessary for Auditing Important Factor II

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

Program Indicators

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

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

How to Determine Compliance with Important Factor II

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

Section II: Food Service

Important Factor III
Program Support

Materials Necessary for Auditing Important Factor III

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

Comment

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

Program Indicators

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

How to Determine Compliance with Important Factor III

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

Section II: Food Service

Important Factor IV
Quality Assurance Program

Materials Necessary for Auditing Important Factor IV

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

Program Indicators

- Determine if:
  a. A written procedure has been developed that describes the jurisdiction's quality assurance program and includes a description of the actions that will be implemented if the review identifies deficiencies in quality or consistency.
  b. The quality assurance program includes a review of a least 15 evaluation reports for each sanitarian and/or an equivalent sample of foodborne illness investigation records every 36 months.
  c. Every employee assigned to the food service program has completed at least 3 joint evaluations with the standardized trainer every 36 months.
  d. The quality assurance program assures that evaluation reports are accurate and properly completed, regulatory requirements are properly interpreted, variances are properly documented, the enforcement policy is followed, foodborne illness investigations are properly conducted, and foodborne illness reports are properly completed.

How to determine compliance with Important Factor IV

- **Met** – A written quality assurance program has been developed. A quality assurance review is conducted at least once every 36 months. At least 15 evaluation reports for each sanitarian's food evaluation and/or foodborne illness investigation records have been reviewed. Every employee assigned to the food service program has completed at least 3 joint evaluations with the trainer every 36 months.

Section II: Food Service

Annex 1 - Corrective Plan of Action

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

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

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

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

Section II: Food Service

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

Instructions and Guidance:

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

Date:

Local Health Dept Name: _____

Your Name: * _____

Title: * _____

Local Health Department Staff Responsible for Implementing Corrective Plan of Action

Name: * _____

Title: * _____

Phone: * * _____

Fax: * * _____

Indicator Not Met

Indicator Description: _____

Corrective Plan of Action (be specific and include details)

Describe Corrective Plan of Action:* *

Projected Completion Date: _____

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

Section II: Food Service

Are there additional materials accompanying this CPA:

○ Yes ◉ No

Additional Material: Reviewer: Date Sent:

Electronic Signature:*

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

☑ Publish

Save

Return to CPA Page

Section II: Food Service

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

Element 3 (detailed plan):

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

Element 4 (monitoring procedure):

A. An office quality assurance review will be conducted by the EH Director and standardized trainer. Files for full-service establishments will be selected for review. The review will determine that consumer advisory and date marking violations are properly documented and corrected.
B. A trend analysis will be conducted to determine the percentage of facilities receiving violations for the two problem areas, to determine consistency between staff, determine violation percentages for full service facilities as compared to the MDARD evaluation report and track trends over time.
C. The agency standardized trainer will initially conduct a minimum of one joint evaluation with each sanitarian approximately 90 days after completion of the previous joint evaluations to assure that the date marking and consumer advisory requirements are being applied properly and uniformly. The joint visits will be made to the same types of facilities that were visited during the MDARD review.

Section II: Food Service

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

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

Annex 2 - Moot Point Principle

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

Application
The MPR in question is considered to be "Met" providing the following elements are documented and demonstrated:

- The deficiency has been completely corrected and in place for at least 12 months prior to the evaluation.
- The deficiency is not likely to recur.

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

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

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

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

Section II: Food Service

Annex 3 – Excerpt from MDHHS General Schedule #7

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

CR = Creation
PERM = Permanent

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

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

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

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

Re-evaluation to Determine Compliance Using Option 1 or 2

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

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

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

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

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

Section II: Food Service

How to Judge Compliance

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

Exit Interview
An Exit Conference will be conducted with the appropriate management staff.

Notification
MDARD will enter the results of the re-evaluation into the Michigan Local Public Health Accreditation Program website.

Waiver of On-Site Review
The MDARD may waive the On-Site Review if it is possible to determine compliance from documentation submitted to MDARD.

Annex 5 - Approved Random Sampling Methods

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

See the Self-Assessment Guidance Document for examples.

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

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

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

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

Method #2: Select every Kth facility

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

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

Section II: Food Service

Annex 6 – Office Sample Size Chart

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

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

Section II: Food Service

Annex 7 – Computer Records

This Annex has been removed for Cycle 7.

Section II: Food Service

Annex 8 - Accreditation Review Document Summary

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

MDARD Provided Documents

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

Local Health Department Provided Documents

- ❑ For Evaluation of Minimum Program Requirements (MPRs)
- ❑ Documentation relating to moot point principle. See MPR Indicator Guide, Cycle 7, Annex 2.
- ❑ Plan Review Log.
- ❑ Plans review files selected for review (all documents and plans relating to review). List of specific files selected will be provided during review.
- ❑ Establishment file for plans selected (pre-opening evaluation and license are needed).
- ❑ Establishment files selected for review (complete and current file, may include, fixed, mobile, STFU, etc.). List of specific files selected will be provided during review.
- ❑ Temporary licenses and evaluations for review period.
- ❑ List of establishments having their licenses limited during review period. Enough information should be on this list to allow these files to be retrieved and reviewed, if requested.
- ❑ List of variances evaluated during review period. Enough information should be on this list to allow these files to be retrieved and reviewed, if requested.
- ❑ Consumer food complaint log and selected complaint files.
- ❑ Foodborne illness complaint log and selected complaint and outbreak investigation files.
- ❑ IAFP 5th edition "Procedures to Investigate Foodborne Illness."
- ❑ Training files for every new employee hired or assigned to the food program since the last accreditation visit. Employees include those who may be occasionally asked to evaluate specialty food service establishments (temporary, STFU, mobile).
- ❑ Policy and procedure documents relating to:
  - plan review (including forms used)
  - conducting evaluations and preparing evaluation reports
  - licensing, including license limitations
  - enforcement, including documentation of policy adoption (by whom and date adopted)
  - variances
  - consumer complaint investigation
  - foodborne illness complaint and outbreak investigation

For Evaluation of Important Factors

- ❑ I - Documentation - quality records needed for this standard reflect activities over the most recent three-year period and include:
  - Minutes, agendas, or other records that forums were conducted,
  - For formal, recurring meetings, such documents as by- laws, charters, membership criteria, and lists, frequency of meetings, roles, etc.,
  - Documentation of performed actions or activities designed with input from industry and consumers to improve the control of risk factors, or

Section II: Food Service

- Documentation of food safety educational efforts. Statements of policies and procedures may suffice if activities are continuous, and documenting multiple incidents would be cumbersome (i.e. recognition provided to establishments with exemplary records or an on-going website).

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

Section II: Food Service

Annex 9 – Approximate Review Timeline for a Single Office Agency
USING OPTION 1

Day	Activity	Documents Needed*	Provided By
1	Field Review: LHD review list of staff and facilities chosen by MDARD and arrange staff assignments as needed.	List of staff and facilities chosen by MDARD for review provided to LHD Friday before on-site visit.	MDARD
	Office Review: MDARD reviewer looks at policies as needed at this point.	Food service policy manual, plus any moot point documentation.	LHD
	MDARD reviewer draws sample of plan review files to be reviewed.	Plan review log for review period. Need to be able to determine which plans were received during review period and which have been completed through pre-opening evaluation.	LHD
	LHD staff pull plans for review.	Plan review documents, including pre-opening evaluation and license application.	MDARD
	MDARD reviewer reviews plans.		LHD
	LHD staff pull establishment files for review.	List of establishment files to be reviewed.	
	MDARD reviewer begins file review if time permits.	Establishment files.	
2	Field: LHD staff accompanies MDARD field reviewer.		MDARD
	Office: MDARD reviewer reads policies.	Food service policy and enforcement policy manuals.	LHD
	MDARD reviewer starts or continues establishment fixed file reviews.	Fixed files for review	
	MDARD reviewer reviews files.		
3	Field: LHD staff accompanies MDARD field reviewer.	Establishment files for facilities visited	LHD

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

Section II: Food Service

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

Section II: Food Service

Day	Activity	Documents Needed*	Provided By
4	Field: MDARD reviewer summarizes results of joint field evaluations and prepares for exit interview.		LHD
	Office: MDARD reviewer reviews documentation relating to important factors and interviews EH director regarding important factor related information. Program managers need to advise MDARD reviewer which IF's the agency is not attempting to meet.	Documentation showing how agency is meeting important factor standards. See documentation summary, MPR Guidance Document, Annex 8.	LHD
	MDARD reviewer summarizes review information and prepares for exit interview.	Copies of various materials made for exit interview. Secretarial assistance usually needed.	

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

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

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

ANNEX 10- ADJUSTMENT OF MPR REVIEW PERIOD

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

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

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

Section II: Food Service

Annex 11- Cycle 5 Food Program Review Options

Review Options

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

Option 1 - MDARD conducts the office and field Review to determine compliance with the standards.
Option 2 - The local health department demonstrates how the agency is in compliance to the MDARD auditor.

Option 2 Review Elements

The Review shall consist of the following elements:

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

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

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

d. MPR 5 - The rating determination shall be based upon:
   1. The oral discussion of field quality assurance activities.
   2. A review of the written quality assurance documentation, including frequency and use of risk-based methodology. A field exercise demonstrating that food program inspectors are properly utilizing a risk–based evaluation methodology using the Field Evaluation Worksheet.

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

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

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

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

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

Criteria to Qualify for Option 2

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

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

Part A:

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

Section II: Food Service

b. Example: On-Site Review is scheduled for March 2011. Normal review period is March 2008-March 2011. Assessment(s) must be completed around March 2010 and cover March 2008-March 2010.

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

Part B:

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

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

Section II: Food Service

	12. Conduct ongoing quality assurance on the following program area: **Enforcement conducted per department policy.**
Miscellaneous	
	13. Conduct ongoing quality assurance on the following program area: **Records properly maintained and filed.**
	14. Conduct ongoing quality assurance on the following program area: **License limitations issued and documented per law.**
	15. Conduct ongoing quality assurance on the following program area: **Variances issued and documented per law.**
	16. Conduct ongoing quality assurance on the following program area: **Consumer complaint investigations (non-illness) properly conducted and documented.**
Training	
	17. Conduct ongoing quality assurance on the following program area: **Technical training for staff conducted per MPR 12 requirements.**
	18. Conduct ongoing quality assurance on the following program area: **Fixed food service evaluation skills for staff conducted per MPR 13 requirements.**
	19. Conduct ongoing quality assurance on the following program area: **Specialty food service evaluation skills conducted per MPR 14 requirements.**
Foodborne Illness	
	20. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigation conducted per MPR 15 requirements.**
	21. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigations conducted per MPR 16 requirements.**

Section II: Food Service

Annex 12 - Cycle 6
Accreditation Review Option 2 Application

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

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

Our agency wishes to use review option 2 for our upcoming Accreditation On-Site Review.

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

Should an agency not meet the automatic approval criteria, the application must be submitted to MDARD at least one year prior to their On-Site Review for a case-by-case review.

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

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

MET NM	Meet 90% of the food program MPRs during the agency's last Accreditation Review.
MET Date(s) completed: NM	Complete a documented program self-assessment covering the normal Accreditation Review period 12 months before the scheduled review date (time may be shortened during for some agencies during initial implementation period). This review shall be completed using the MDARD Self-Assessment Guide (MPR 5 does not need to be reviewed).
MET NM	Conduct quality assurance reviews of existing staff in field (i.e. FDA Voluntary Retail Standard 2 or Important Factor IV contain quality assurance guides).

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

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

Program Advancement

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

Section II: Food Service

MET NM	1. Maintain at least one food program agency staff member that is MDARD standardized.
MET NM	2. Enroll in FDA Voluntary Retail Standards
MET NM	3. Maintain a tracking system to monitor risk factor occurrence in establishments, compare with state risk-reduction surveys and local historical records for the purpose of program improvement.
MET NM	4. Regularly utilize and document use of long term control measures (i.e. such as risk control plans) with food establishments to assist in obtaining long term compliance.
Plan Review	
MET NM	5. Conduct ongoing quality assurance on the following program area: **Plan reviews properly conducted and documented**
MET NM	6. Conduct ongoing quality assurance on the following program area: **Pre-opening evaluations properly conducted and documented**
MET NM	7. Conduct ongoing quality assurance on the following program area: **Unauthorized construction recognized and controlled**
Evaluations	
MET NM	8. Conduct ongoing quality assurance on the following program area: **Evaluation frequency meets required schedules**
MET NM	9. Conduct ongoing quality assurance on the following program area: **Follow-up evaluations meet required schedules**
MET NM	10. Conduct ongoing quality assurance on the following program area: **Evaluation procedures meet MPR 4 requirements**
MET NM	11. Conduct ongoing quality assurance on the following program area: **Temporary food service establishment evaluations properly conducted and documented**
MET NM	12. Conduct ongoing quality assurance on the following program area: **Enforcement conducted per department policy**
Miscellaneous	
MET NM	13. Conduct ongoing quality assurance on the following program area: **Records properly maintained and filed**
MET NM NA	14. Conduct ongoing quality assurance on the following program area: **License limitations issued and documented per law**
MET NM NA	15. Conduct ongoing quality assurance on the following program area: **Variances issued and documented per law**
MET NM	16. Conduct ongoing quality assurance on the following program area: **Consumer complaint investigations (non-illness) properly conducted and documented**
Training	
MET NM NA	17. Conduct ongoing quality assurance on the following program area: **Technical training for staff conducted per MPR 12 requirements**

Section II: Food Service

MET NM NA	18. Conduct ongoing quality assurance on the following program area: **Fixed food service evaluation skills for staff conducted per MPR 13 requirements**
MET NM NA	19. Conduct ongoing quality assurance on the following program area: **Specialty food service evaluation skills conducted per MPR 14 requirements**
Foodborne Illness	
MET NM	20. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigation conducted per MPR 15 requirements**
MET NM	21. Conduct ongoing quality assurance on the following program area: **Foodborne illness investigations conducted per MPR 16 requirements**

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

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

Review

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

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

Communication

The Field Evaluation Worksheet along with the risk-based inspection process evaluated during Cycle 7 Accreditation, Option 2, stresses open communication between the evaluator and operator. To be an effective communicator, the evaluator is expected to ask questions relative to the flow of food through the establishment, preparation and cooking procedures, employee health, and normal everyday operation of the facility (i.e., GRPs). Response statements made by the person in charge (PIC) or food employees should be used to support or augment direct observations. When observations are made while a food is undergoing a process (i.e., cooling and reheating), the evaluator should ask the PIC or food employees questions to support the actual observations and determine Food Code/Food Law compliance.

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

- There will be no interaction, guidance or training from the MDARD auditor to the food service evaluator during the audit. It is expected that the evaluator will verbally address all findings of either compliance or noncompliance throughout the entire Accreditation exercise. **Communication** is the only way for the auditor to know what the evaluator is seeing, and how compliance is determined.
- At the end of the Accreditation exercise the evaluator will be given time to look over their notes, check sheets, or any other guidance form that they use for the evaluation to ensure they have completed the inspection. Any additional information obtained by the evaluator, prior to leaving the facility, may be communicated to the auditor.
- Once the auditor and evaluator leave the facility, the Accreditation exercise is over. No changes may be made to the auditor's report.
- To maintain consistency throughout the process, there will be no feedback given from the auditor to the evaluator after the Accreditation exercise. On the same note, there will be no feedback given from the auditor to the Environmental Health Director or Food Supervisor until all Accreditation exercises are complete, and compliance with MPR 5 is determined.

GUIDELINES FOR DETERMINING EVALUATOR COMPETENCY

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

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

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

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

II. Inspections, Observations, and Performance

(C) Risk Based Inspection/Active Managerial Control

1. Verified demonstration of knowledge of the person in charge.

- For the evaluator to be marked YES in this category the following items must be evaluated:
  a. PIC present.
- Determine presence of PIC:
  a. The person responsible for monitoring and managing shall be immediately available and knowledgeable in operational procedures and Food Code/Food Law requirements.
  b. Demonstration of knowledge.
- Determine that the PIC meets at least one of these three criteria:
  a. Certification by an ACCREDITED PROGRAM per §2-102.20.
  b. Compliance with the Code and Law by having no violations of critical items during the current inspection.
  c. Correct responses to the inspector's questions regarding public health practices and principles applicable to the operation.

Section II: Food Service

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

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

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

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

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

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

4. **Verified approved food sources (e.g., food from regulated food processing plants; shellfish documentation; wild game and mushrooms, game animal processing; parasite destruction for certain species of fish intended for raw consumption; receiving temperatures).**
   - In order for the evaluator to be marked YES in this category the following items must be evaluated:
     a. All foods are from a regulated food processing plant or other approved source (no home prepared items).
     b. Foods are received at proper temperatures, protected from contamination during transportation, and received safe and unadulterated.

c. Determine if any specialty food items are served or specialty processing is done (i.e. wild game or mushrooms, game animal processing, and parasite destruction).

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

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

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

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

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

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

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

combination with temperature measurements taken, should form the basis for assessing compliance of cooling during an inspection.

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

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

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

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

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

12. **Verified food contact surfaces are clean and sanitized, protected from contamination from soiled cutting boards, utensils, aprons, etc., or raw animal foods.**
    - In order for the evaluator to be marked YES in this category the following items must be evaluated:

Section II: Food Service

a. Evaluate food-contact surfaces of equipment and utensils to verify that these are maintained, cleaned, and sanitized.
b. Assess how utensils and cookware are washed, rinsed, and sanitized.
c. Evaluate type of sanitizer, concentration, proper use, and use of chemical test strips.

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

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

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

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

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

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

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

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

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

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

Section II: Food Service

(E) Good Retail Practices

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

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

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

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

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

Section III: General Communicable Disease Control

MPR 1

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

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

Indicator 1.1

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Question:

None

Indicator 1.2

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

For technical assistance, please contact Shannon Johnson (johnsons61@michigan.gov) at 517-284-4962 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690

Section III: General Communicable Disease Control

This indicator may be met by:

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

Documentation Required:

Evidence that weekly surveillance log is monitored and signed-off on a weekly basis by the CD/Nursing Supervisor, Epidemiologist, or Medical Director. It is highly recommended that weekly analyses are maintained electronically.

Evaluation Question:

None

Indicator 1.3

The local health department electronically submits CD cases and case report forms that are complete, accurate, and timely to MDHHS by utilization of the MDSS.

Note: A random sample of case reports will be pulled out of MDSS by the Reviewer prior to the Review for evaluation of this indicator.

This indicator may be met by:

- Evidence of MDSS and case report form utilization; **AND**
- Entry within 1 business day of received CD reports into the MDSS; **AND**
- Within 7 days of receipt, at least 90% of case demographic data (name, address, age/date of birth, sex, race, and ethnicity) and pertinent case data (onset date, diagnosis date, hospitalization status) is completed in MDSS; **AND**
- Upon case completion, at least 90% of the detailed case report form's available fields are accounted for/filled in/completed. Information that cannot be obtained should be documented. To meet this indicator, 90% of the cases pulled by the Reviewer (e.g., 18/20) will have to meet the above criteria; **AND**
- Cases are updated, reactivated, and/or reclassified in MDSS as new information is obtained (e.g., laboratory serogroups and serotype results, patient outcome, and outbreak identification).
- **(Special Recognition)** The local health department may also have an internal review or audit process for improvement of data quality.

Section III: General Communicable Disease Control

Documentation Required:

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

Documentation Requested:

(Special Recognition) Provide evidence of internal review process or audit that includes an aspect of data quality improvement.

Evaluation Question:

None

Indicator 1.4

The local health department shall create an annual report that includes aggregate CD data for dissemination throughout the local health department's jurisdiction.

This indicator may be met by:

- The local health department maintains and displays CD case counts in an annual report that can be distributed to interested entities such as community physicians, infection control, and private citizens. The annual report should include aggregate data to illustrate the jurisdiction's CD trends.
- **(Special Recognition)** The local health department may also disseminate a quarterly update with similar data to the above groups of people.

Documentation Required:

- Annual report of communicable diseases within your jurisdiction. The report should include an analysis and interpretation of public health data with conclusions drawn from the data.
    - Examples: comparing a 5-year disease average to current year disease counts; or including a narrative about data findings or discussing a specific condition of interest (e.g., local increase in HCV).
- List of stakeholders who receive Annual Report/quarterly updates.

Documentation Requested:

(Special Recognition) Quarterly updates or other news bulletins that get disseminated through the local health department's jurisdiction.

Section III: General Communicable Disease Control

MPR 2

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

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

Indicator 2.1

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Question:

None

Indicator 2.2

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

This indicator may be met by:

- The local health department investigates individual case reports; **AND**
- The local health department conducts investigations of CD outbreaks and clusters; **AND**
- The local health department maintains protocols of specific CDs that are required to be reported by Michigan laws or rules.

For technical assistance, please contact Shannon Johnson (johnsons61@michigan.gov) at 517-284-4962 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690

Section III: General Communicable Disease Control

Documentation Required:

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

Evaluation Question:

None

Indicator 2.3

The local health department shall notify MDHHS immediately of a suspected CD outbreak in their jurisdiction.

This indicator may be met by:

- The local health department notifies MDHHS within 24 hours when their jurisdiction suspects a CD outbreak. Notification can be via phone, fax, MDSS (must include an outbreak identifier), or Notification of Serious Communicable Disease form; **AND**
- The local health department has a protocol that declares who at the local health department notifies MDHHS and what specific information should be relayed (e.g., possible pathogen, source, number ill, facility); **AND**
- The local health department maintains a file of outbreaks investigated in their jurisdiction. This review will exclude isolated complaints on the Environmental Health (EH) foodborne illness complaint log. However, reports (6-point narratives) from outbreaks that are co-investigated by both EH and CD will need to be provided for this review, as epidemiological components of the outbreak will be reviewed.
- **(Special Recognition)** To improve reporting and public health control measures, the LHD reports all outbreaks into MDSS via the aggregate form. Large outbreaks are managed using the MDSS Outbreak Management System (OMS).

Documentation Required:

- The local health department chosen means for MDHHS notification.
- Protocol for notifying MDHHS.
- Outbreak investigation folder.

Section III: General Communicable Disease Control

Documentation Requested:

(Special Recognition)

- Outbreak file contains evidence that outbreaks were entered into MDSS via the aggregate form (e.g., exported line list, MDSS investigation IDs) **OR** outbreak file contains evidence that OMS was utilized to manage one or more outbreaks.

Evaluation Question:

None

Section III: General Communicable Disease Control

MPR 3

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

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

Indicator 3.1

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Question:

None

Indicator 3.2

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

This indicator may be met by:

- The local health department can demonstrate timely case follow-up, follow-up efforts, and completion/updates of cases in MDSS; **AND**
- The local health department maintains control guidelines or other guidance materials to assist in the control of disease spread (e.g., Norovirus Control Guidelines in Nursing Homes, etc.) that can be distributed to community partners; **OR**
- Additional educational materials, fact sheets, or other guidance documents that will assist the local health department with prevention of disease transmission.

For technical assistance, please contact Shannon Johnson (johnsons61@michigan.gov) at 517-284-4962 or Tim Bolen (bolenT1@michigan.gov) at 989-832-6690

Section III: General Communicable Disease Control

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

Documentation Required:

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

Documentation Requested:

- Control guidelines or other guidance materials to assist in the control of disease spread (e.g., Norovirus Control Guidelines in Nursing Homes, etc.) that can be distributed to community partners.
- Additional educational materials, fact sheets, or other guidance documents that will assist the local health department with prevention of disease transmission.
- **(Special Recognition)** CD presentations to educational venues such as conferences and community health education fairs.

Evaluation Question:

None

Indicator 3.3

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

This indicator may be met by:

- Staff has access to current and up-to-date reference materials (e.g., Control of Communicable Diseases Manual; Red Book; Brick Book; Michigan Communicable Disease Handbook; CDC Core Curriculum on Tuberculosis; MMWR case definitions; FIRST, Rabies, Head lice, and Scabies manuals, etc.); **AND**
- Attendance of professional development activities (which may offer CME, CEU, or contact hours), which may include in-services, conferences, seminars, and trainings.

Documentation Required:

- Local health department has documentation of CD staff participation in professional development activities, conferences, seminars, and/or trainings.
- The documentation for the above indicator may include either a copy of the CEU certificate or a listing of activities attended for a given year, along with the date of the activity.

Evaluation Question:

None

Section III: General Communicable Disease Control

Indicator 3.4

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

This indicator may be met by:

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

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

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

Documentation Required:

Copies of completed CDC 52.13 and CDC 52.12 forms

Evaluation Question:

None

Section IV: Hearing

MPR 1

The local health department shall provide hearing screening services for preschool age children between the ages of 3 and 5 years.

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

Indicator 1.1

Program activity reports and statistics document the provision of hearing screening to children between the ages of 3 and 5 years in preschool, Head Start, and child care programs.

This indicator may be met by:

- A schedule or agency calendar documenting hearing technician assignments and/or responsibilities for the current year showing preschool children who were scheduled and received hearing screening services; **AND**
- A written policy or program plan articulating procedures for hearing screening for children between the ages of 3 and 5 years; **AND**
- A list of all preschool, Head Start, and child-care programs scheduled to receive hearing screening services for the current year: **AND**
- The local health department quarterly statistical records indicating the number of preschool age children screened for the past year.

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Section IV: Hearing

MPR 2

The local health department shall provide hearing screening services for school-age children every other year through grade 4.

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

Indicator 2.1

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

This indicator may be met by:

- A schedule or agency calendar documenting hearing technician assignments and/or responsibilities for the current year; **AND**
- A written policy or program plan articulating the level of frequency for hearing screening for school-age children; **AND**
- A list of all schools scheduled to receive hearing screening services for the current year; **AND**
- The local health department quarterly statistical records indicating the number of school-age children screened for the past year.

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Section IV: Hearing

MPR 3

The local health department shall assure that hearing screening is conducted in accordance with the Michigan Department of Health & Human Services (MDHHS) Hearing Technician's Manual (DCH0519B, Rev. 6/03).

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

Indicator 3.1

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Indicator 3.2

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Section IV: Hearing

Evaluation Question:

None

Indicator 3.3

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Section IV: Hearing

MPR 4

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

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

Indicator 4.1

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Indicator 4.2

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Section IV: Hearing

MPR 5

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

Reference: Michigan Administrative Code, R 325.3273.

Indicator 5.1

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

This indicator may be met by:

Hearing technician certificates confirming that technicians have participated and passed the approved MDHHS training course for the Hearing Screening Program.

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Indicator 5.2

All hearing technicians have attended at least one MDHHS approved skills workshop within the last 24 months.

This indicator may be met by:

The local health department maintains on file attendance certificates from MDHHS Annual Technician Workshops.

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Section IV: Hearing

MPR 6

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

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

Indicator 6.1

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

This indicator may be met by:

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

Documentation Required:

See the 'This indicator may be met by:' section for this indicator.

Evaluation Question:

None

Accreditation Tool 2018

Michigan Local Public Health Accreditation Program

Section V: Immunization

MPR 1

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

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

Indicator 1.1

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

This indicator may be met by:

The LHD shows evidence of the capability to vaccinate susceptible individuals in the event of a vaccine preventable disease outbreak or threatened epidemic of a vaccine preventable disease.

Documentation Required:

- Written policies/protocols/operating procedures for public health preparedness during a vaccine preventable disease outbreak or threatened epidemic of a vaccine preventable disease.

Evaluation Questions:

- Has the policy/protocol/operating procedure for setting up a mass vaccination clinic in case of an outbreak of a vaccine preventable disease been reviewed and updated annually?
- Does the LHD policy/protocol/operating procedure for setting up clinics in settings other than the health department's clinics coincide with the current CDC Storage and Handling Guidance for maintaining vaccine viability?
- Does the LHD have access to the CDC Manual for Surveillance of Vaccine-Preventable Diseases and to the most current MDHHS Vaccine Preventable Disease Investigation Guidelines?

Indicator 1.2

LHD conducts free periodic immunization clinics for those residing in its jurisdiction. Clarification: "free periodic immunization clinics" refers to public vaccine, particularly Vaccines for Children Program (VFC) vaccine, Adult Vaccine Program (AVP) vaccine, and Section 317 funded vaccine. The LHD must be conducting clinics and administering vaccines.

This indicator may be met by:

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

Documentation Required:

- Written policies/protocols/operating procedures for the appropriate vaccination of all LHD clients
- Documentation of all walk-in and appointment based clinic hours and locations showing availability to meet the public demand
- LHD VFC enrollment and profile forms for the past three years

Evaluation Questions:

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

Indicator 1.3

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

This indicator may be met by:

a) The LHD submits semi-annual Immunization Action Plan (IAP) reports on or before the due date each year.

b) The LHD submits an annual IAP plan by the due date each year.

c) At least one representative from each local health department will attend the IAP meetings held twice a year.

Documentation Required:

- IAP reports submitted and on file at the LHD for the last 3 years
- IAP plans submitted and on file at the LHD for the last 3 years

Evaluation Questions:

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

Indicator 1.4

The local health department shows evidence of clientele reminder/recall for Advisory Committee on Immunization Practices (ACIP) vaccines not up to date.

This indicator may be met by:

a) The LHD will maintain a policy/protocol/operating procedure on the process for their recall efforts.

b) The LHD conducts quarterly reminder and/or recall efforts for their health department clients and details which methods were used on a chart or a graph (cards, letters, phone calls, other methods of outreach).

c) The LHD participates in collaborative efforts with private providers to promote/implement a recall system.

Documentation Required:

- Current policy/protocol/operating procedure on LHD reminder/recall.
- Documentation of reminder/recall efforts on a graph or spreadsheet outlining the number of reminder and/or recall notices sent to LHD clients, details about which methods were used (cards, letters, phone calls, emails, texts, or other methods of outreach), date, antigens/ages recalled, and number of letters/phone calls/etc.
- Review of three client records that have been tracked showing response to recall
- Documentation of ongoing efforts to work with private providers to promote reminder/recall activities (e.g. educational, MCIR-related, or other collaborative efforts)

Section V: Immunization

Evaluation Question:

- How does the LHD determine the focus areas for their reminder/recall efforts?

MPR 2

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

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

Indicator 2.1

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

This indicator may be met by:

a) Barriers to vaccination should be identified and minimized at the local health department.

b) Patient "out-of-pocket" costs are minimized.

c) Vaccinations are coordinated with other healthcare services being provided at the health department.

d) Clients seeking healthcare services at a local health department should be assessed at every encounter to determine which vaccines are indicated.

e) Office or clinic-based patient record reviews and vaccination coverage assessments are performed annually.

Documentation Required:

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

Evaluation Questions:

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

For technical assistance, please contact Terri Adams at 517-284-4872 or Adamst2@michigan.gov

- How does the LHD perform clinic based patient record reviews?
- Does the LHD perform vaccination coverage assessments for their clients?

Indicator 2.2

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

This indicator may be met by:

a) All locations where vacines are administered have written up-to-date vaccination protocols that are easily accessible at all locations where vaccines are administered.

b) Local health department staff should simultaneously administer as many indicated vaccine doses as possible.

c) Only true contraindications should be used when vaccinating individuals.

d) Proper counseling of persons receiving vaccines should be performed, explaining immunization risks and benefits, including the distribution of the Michigan VIS.

e) All required fields for vaccination must be properly documented and records are easily accessible.

Documentation Required:

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

Evaluation Questions:

- Are current ACIP recommendations published in the Morbidity and Mortality Weekly Report (MMWR), ACIP/VFC resolutions, and guidelines to contraindications for pediatric and adult immunizations included in the standing orders?
- Are the vaccine protocols/standing orders easily accessible to all LHD staff?

- Does a review of LHD client vaccine administration records show that there are no missed opportunities to vaccinate?

- Does a review of LHD client vaccine administration records at all clinics show that all required immunization documentation is correct?

- How are declinations to immunization for clients of all ages documented at the LHD?

Indicator 2.3

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

This indicator may be met by:

a) LHD ensures that immunization staff has been properly trained and updated on immunization practices.

b) Personnel who have contact with patients are encouraged to be appropriately vaccinated.

Documentation Required:

- Policy/Protocol/Operating Procedure on staff orientation including the required annual staff training.

- Log or chart documenting evidence of a minimum of 6 hours of annual staff training regarding current immunization practices/standards during the past three years and a list of CE/CNE's for those who administer vaccine to ensure immunization staff has been properly trained

- Log or chart documenting evidence of a minimum of 6 hours of annual training regarding current immunization practices/updates during the past three years that the Medical Director has received

- Public Health Nurse (PHN) immunization orientation plan to assure immunization staff has been properly trained

- Evidence of encouragement and/or programs to vaccinate LHD staff

Evaluation Questions

- Has the IAP Coordinator and all staff administering vaccines received at least 6 hours of annual training related to immunization?

- Does the LHD have an Immunization Nurse Education (INE) session annually for all immunization staff?

- Has the Medical Director received at least 6 hours of annual training related to immunization?
- How does the LHD assure proper vaccination of all staff?
- How does the LHD handle immunization education for part time or temporary staff?

Indicator 2.4

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Questions:

- What efforts does the LHD undertake to promote adult immunizations?
- Does the LHD carry all age appropriate vaccines for their adult clients?
- How does the LHD promote the vaccination of all of the adults in their jurisdiction?
- How is the LHD promoting the use of MCIR for all adult immunizations?
- How does the LHD identify and address immunization disparity issues within their jurisdiction?

MPR 3

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

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

Indicator 3.1

The local health department shall assure adequate storage and handling of vaccines that it administers and distributes. **(Immunization Program Operations Manual - 2013-2017 and Omnibus Reconciliation Act of 1993)**

This indicator may be met by:

a) Annual enhanced VFC site visits at each LHD vaccine storage site with no outstanding issues.

b) The local health department has appropriate equipment and monitoring devices to safely store vaccine at each of its clinic sites.

c) The local health department can demonstrate that all staff responsible for storage and handling of vaccines are familiar with and have access to the most current CDC storage and handling guidelines and other guidelines, information, and policies related to storage and handling that are provided by MDHHS.

d) The local health department has procedures in place to assure appropriate storage of vaccines and demonstrates these procedures.

e) The local health department uses appropriate storage and handling methods in the ordering of vaccines and the transport of vaccines to off-site clinics and to other providers.

Documentation Required:

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

- The name and location of an adequate back-up storage site and the written agreement updated annually stating that the site will serve as back-up for vaccine storage.

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

- Calibration charts from the last three months showing weekly documentation of the alarm temperature, and Data Logger or other continuous temperature recording device reading as compared to a certified thermometer reading. Calibration charts must also show documentation of any adjustments made to the alarm or other temperature monitoring devices during each weekly time period to bring all devices within three degrees Fahrenheit or 1.5 degrees Celsius of the certified thermometer temperature.

- Written policy within the Immunization Manual requiring the use of coolers and appropriate coolant when transporting vaccine following the most current CDC guidelines.

Evaluation Questions:

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

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

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

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

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

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

- Does the local health department have the current CDC Vaccine Storage and Handling Toolkit in view and at all vaccine storage sites?

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

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

- Does the LHD have a written back-up generator plan if there is a generator in use?

- Does a review of the Data Logger thermometer (or other continuous monitoring thermometer) for the past 90 days show temperatures within range at all times, that the Data Logger has been downloaded weekly and that the graphs match the calibration chart readings?

- Is the vaccine monitoring system functional and a review of the settings of the system shows the ability to notify personnel in case of a vaccine management emergency?

- There are no accident reports attributable to negligence on the part of the LHD filed, without satisfactory resolution of the problem, for any of its sites since its last Accreditation On-Site Review

- Are vaccines handled appropriately in the clinic setting between main storage and administration of the vaccine?

Indicator 3.2

The local health department shall assure that all requirements for participation in vaccine programs (including VFC and other vaccine distribution programs) are met. **(Reference: Vaccines for Children Operations Guidelines, November 2012)**

This indicator may be met by:

- The local health department reviews the Michigan Department of Health and Human Services (MDHHS) VFC provider enrollment form and profile form for the agency and for each participating health care provider, including each community/migrant/rural health center in its jurisdiction via the MCIR, by the submission due date: April 1.

  a) The local health department completes the Michigan Department of Health and Human Services vaccine dose reporting forms, temperature charts, and vaccine inventory forms and submits to MDHHS as supporting documentation with orders.

  b) The LHD processes provider VFC vaccine orders in a timely manner and assures that ordering requirements are met for each scheduled order.

  c) The local health department adheres to ACIP recommendations published in the MMWR, ACIP/VFC resolutions, and guidelines to contraindications for pediatric, adolescent and adult immunizations.

  d) The local health department maintains on file a sample of informational material provided to private providers regarding requirements for the VFC Program during the enrollment process.

  e) The local health department will perform VFC/AFIX site visits to VFC providers in its jurisdiction, according to minimum and maximum standards formulated by MDHHS.

f) The local health department documents and reports to MDHHS appropriate follow-up plans resulting from VFC/AFIX site visits.

g) The LHD assures that all providers resolve VFC vaccine losses according to MDHHS/CDC procedures and timelines.

h) The local health department assesses and documents each client's eligibility for the VFC Program and other publicly funded vaccine programs.

i) The LHD works with providers to avoid vaccine fraud, abuse and wastage.

Documentation Required:

- Documentation of required number of VFC/AFIX site visits completed for the past 3 years with all follow-up plans addressed. VFC Providers must have a VFC/AFIX visit at least every other year. The city of Detroit is expected to visit 100% of their providers annually using Quality Assurance Specialists (QAS) as assigned to Detroit.

- Documentation of required AFIX visits and all AFIX follow-up visits.

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

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

- Current policy/protocol/operating procedure on the timely processing of VFC provider vaccine orders to include the review and assessment of supporting documentation according to MDHHS guidance.

- Current policy/protocol/operating procedure on the Lost/Waste/Borrowed vaccines report including monthly submission of report for all VFC providers utilizing the MCIR Loss Report function.

- Current policy/protocol/operating procedure for the LHD and all VFC providers residing in the jurisdiction on the timely replacement of VFC Vaccine due to loss according to MDHHS/CDC guidance.

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

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

Evaluation Questions:

- Does a review of LHD vaccine orders show that the LHD has submitted and reviewed the supporting documentation required with their own vaccine orders?
- Is the LHD following the current policy/protocol/operating procedure on the timely processing of VFC provider vaccine order?
- Does a review of provider vaccine orders show that the LHD has reviewed the order and required supporting documentation submitted with the order?
- Is the LHD profile consistent with the amount of vaccine ordered?
- How does the LHD target providers for VFC/AFIX site visits with storage and handling issues or other vaccine management issues?
- Does the LHD conduct the combined VFC/AFIX visit at site visits for providers who have any children in the 24 – 36 month age range?
- Does the LHD conduct VFC/AFIX visits at site visits with providers who have any adolescents in the 156-216 month age range?
- Can the LHD show examples of efforts to educate providers on vaccines, immunization guidelines and publicly purchased vaccine program guidelines?
- Are LHDs training and educating providers on creating and submitting the Return/ Waste reports on a minimum of a monthly basis?
- Are all vaccine loss reports within the health jurisdiction reported according to MDHHS procedures?
- Are VFC Vaccine losses handled according to MDHHS/CDC guidance?
- Are there any outstanding unresolved VFC Vaccine Losses for the LHD or the VFC Providers in the jurisdiction?
- Does the LHD have a least one Nurse trained in the MDHHS Immunization Nurse Educator Program?

MPR 4

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

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

Indicator 4.1

The local health department shall sustain an immunization level for their jurisdiction in MCIR of at least 72% for children who are aged 24 to 36 months for four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity); and four (4) doses of pneumococcal conjugate vaccine (or complete series).

The local health department shall also assess the immunization coverage level for their jurisdiction in MCIR children aged 24 to 36 months for four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity), four (4) doses of pneumococcal conjugate vaccine (or complete series); and two (2) doses of hepatitis A vaccine.

This indicator may be met by:

a) A jurisdiction rate, at or above, 72% for the 4:3:1:3:3:1:4 vaccine series as shown by MCIR county profile report(s) created within 30 days of the Accreditation On-Site Review.

Documentation Required:

- MCIR Profile Report(s) showing the number and percent of children aged 24 to 36 months who have received four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity), and four (4) doses of pneumococcal conjugate vaccine (or complete series), (4:3:1:3:3:1:4 series) for all counties in the jurisdiction within 30 days of the Accreditation On-Site Review.

- MCIR Profile Report(s) showing the number and percent of children aged 24 to 36 months who have received four (4) doses of DTaP vaccine; three (3) doses of polio vaccine; one (1) dose of MMR vaccine; three (3) doses of Hib vaccine (or complete series); three (3) doses of hepatitis B vaccine; one (1) dose of varicella vaccine (or documented immunity), four (4) doses of pneumococcal conjugate vaccine (or complete series), and two (2) doses of hepatitis A vaccine. (4:3:1:3:3:1:4:2 series) for all counties in the jurisdiction within 30 days of the Accreditation On-Site Review.

- Written protocol included in the Immunization Manual to detailing strategies on increasing immunization coverage levels for the 4:3:1:3:3:1:4:2 series in the MCIR for children aged 24 to 36 months which includes efforts to reach identified pocket of need areas.

Evaluation Questions:

- Has the local health department reached at least a 72% level for children aged 24 to 36 months within the local health department's jurisdiction as recorded in the MCIR for the 4:3:1:3:3:1:4 series within 30 days of the Accreditation On-Site Review?

- Does the LHD assess, on a monthly basis, the rates for 4:3:3:1:3:3:1:4:2?

Indicator 4.2

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

This indicator may be met by:

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

Documentation Required:

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

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

Evaluation Question:

- What efforts has the LHD conducted to target and increase adolescent immunization coverage levels for all of the recommended antigens in the jurisdiction?

- What efforts has the LHD conducted to increase the immunization coverage levels for human papillomavirus (HPV) vaccine in the jurisdiction?

Indicator 4.3

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

This indicator may be met by:

a) There is evidence that 90% of clients below the age of 20 years receiving immunizations at the local health department (all clinics in jurisdiction combined) have their immunization data submitted to MCIR within 72 hours. **(Reference: Administrative Rule 325.163, § 5)**

Documentation Required:

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

Evaluation Question:

- Did 90% of the clients below the age of 20 years receiving immunizations at the local health department (all clinics in jurisdiction combined) have their immunization data submitted to the MCIR within 72 hours of vaccine administration?

MPR 5

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

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

Indicator 5

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

The local health department will assure complete and accurate reporting of childcare center immunization data by February 1st of each year to MDHHS utilizing the MCIR/SIRS reporting program. (**Reference: PH code 333.9208)**

This indicator may be met by:

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

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

Documentation Required:

- MDHHS Protocols for the current school year.
- Policy/protocol/operating procedure on the LHD process that details the methods used for reviewing and assuring that childcare and school immunization data are complete and accurate.
- IP-100 and IP-101 County status reports for each reporting period for the past three years.
- Documentation showing timely submission of complete and accurate school data by December 15 and March 15 of each year.
- Documentation showing timely submission of complete and accurate childcare data by February 1 of each year.
- Evidence of follow-up for non-compliant or delinquent childcare centers and schools which appear on the status reports.

For technical assistance, please contact Terri Adams at 517-284-4872 or Adamst2@michigan.gov

Evaluation Questions:

- Does the LHD update/maintain the childcare and school facility master listings in MCIR/SIRS?
- What methods are used by the LHD to promote that data submitted by childcare centers and schools is complete and accurate?
- How does the LHD monitor and evaluate the immunization completion rate of children in childcare?
- How does the LHD monitor and evaluate the immunization completion rate of school age children?
- Does the LHD's Waiver Policy follow MDHHS Administrative Rules?

MPR 6

The local health department complies with vaccine safety recommendations.

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

Indicator 6.1

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

This indicator may be met by:

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

Documentation Required:

- VAERS written policy in the Immunization Manual which includes information on utilization of up to date reporting forms (available at the U.S. Department of Health & Human Services VAERS website) and the ability to submit VAERS reports online.

- Copies of all VAERS reports filed by the LHD in the last three years (either electronically or on paper forms) showing correct documentation on up to date forms.

Evaluation Question:

- How is the LHD educating all immunization providers (both VFC and non-VFC) who administer vaccines within the jurisdiction on entering reportable adverse events after vaccination into the VAERS system?

Indicator 6.2

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

This indicator may be met by:

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

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

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

Documentation Required:

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

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

Evaluation Question:

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

- How does the LHD maintain the VIS dates in their electronic medical records/electronic health records (EMR/EHR) (if applicable)?

Indicator 6.3

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

This indicator may be met by:

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

Documentation Required:

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

Evaluation Question:
None

Section VI: Onsite Wastewater Treatment Management

MPR 1

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

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

Indicator 1.1

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

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

Evaluating Compliance:

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

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

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

Section VI: Onsite Wastewater Treatment Management

Indicator 1.2

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

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

Evaluating Compliance:

Met – The On-Site Review determines all of the following:

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

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

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

Section VI: Onsite Wastewater Treatment Management

Indicator 1.3

Evidence that actual enforcement measures are utilized.

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

Evaluating Compliance:

Met – The On-Site Review determines all of the following:

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

Met with Conditions – The On-Site Review determines any of the following:

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

Not Met – The On-Site Review determines any of the following:

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

Section VI: Onsite Wastewater Treatment Management

MPR 2

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

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

Indicator 2.1

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

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

- Determine that documentation of all site evaluations minimally identify the following essential elements:
    - The location of the soil boring(s) or excavation(s), which establish the approved area for the proposed absorption system to be installed, shall be documented in a verifiable manner (see Appendix B).
    - Soil profile data
        - Soil texture for each distinct horizon* inclusive of topsoil to the depth of the boring or excavation.
        - The use of non-USDA textural terms in the logging of the soil profile would not result in a "Not Met" during Cycle 7.
        - The use of a generic descriptor for topsoil would not result in a "Not Met" during Cycle 7.
        - Thickness of each soil horizon to the depth of the boring or excavation.

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

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

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

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

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

Evaluating Compliance:

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

Met with Conditions – At least 70 percent or more of site evaluation documents reviewed contain all of the essential elements and/or greater than 30 percent of the site evaluation documents reviewed contain non-USDA soil texture terminology in the logging of the soil profile.

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

Indicator 2.2

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

To fully meet this indicator:

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

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

Documentation Required:

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

- Local health department onsite wastewater policy manual.

Section VI: Onsite Wastewater Treatment Management

Compliance Measurement:

Permit documentation includes the following essential elements:

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

Evaluating Compliance:

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

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

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

Indicator 2.3

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

To fully meet this indicator:

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

Section VI: Onsite Wastewater Treatment Management

Documentation Required:

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

Compliance Measurement:

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

Evaluating Compliance:

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

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

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

Section VI: Onsite Wastewater Treatment Management

MPR 3

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

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

Indicator 3.1

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

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

- Date of final inspection
- Name or initials of staff person conducting the inspection

- Affidavits – If used:

  - Unless specific authorization has been granted, determine that no more than 10 percent of the total numbers of final inspections are installer affidavits through the logbook and/or database, or other method that documents affidavit use.
  - Determine that documentation of installer affidavits for final inspections include the following essential elements:
    - A drawing and component verification which identifies the essential elements and key components outlined in Compliance Measurement for Indicator 3.1
    - Date of the installation
    - The installer's name

Evaluating Compliance:

Met – The On-Site Review determines all of the following:

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

Met with Conditions – The On-Site Review determines all of the following:

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

Not Met – The On-Site Review determines any of the following:

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

Section VI: Onsite Wastewater Treatment Management

MPR 4

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

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

Indicator 4.1

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

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

Evaluating Compliance:

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

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

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

Section VI: Onsite Wastewater Treatment Management

MPR 5

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

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

Indicator 5.1

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

*Note: For the purpose of this guidance, a system consists of a tank or tanks, absorption system, and associated appurtenances. A system is considered to have failed when sewage backs up into the home or structure, discharges to the ground surface, contaminates surface water, or drinking water supplies, any part of the system is bypassed, the system is the source of an illicit discharge, there is an absence of an absorption system, or there is a structural failure of a septic tank or other associated appurtenances.

To fully meet this indicator:

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

Documentation Required:

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

Compliance Measurement:

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

For technical assistance, please contact Dale Ladouceur at 517-284-6534 or ladouceurd@michigan.gov

Section VI: Onsite Wastewater Treatment Management

Evaluating Compliance:

Met – The On-Site Review determines all of the following:

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

Not Met – The On-Site Review determines any of the following:

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

Section VI: Onsite Wastewater Treatment Management

Appendix A

PERMIT SELECTION PROTOCOL

Goal – To collect and evaluate a representative random number of finalized wastewater permits to evaluate compliance with the Onsite Wastewater Treatment Management program Indicators VI-2.1, VI-2.2, and VI-3.1.

Method

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

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

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

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

Examples:

1. A department that has reported issuing 200 wastewater permits in a fiscal year with two staff members working the Onsite Wastewater Program will have a permit sample size of 10 permits.
   - 200 permits x 4% = 8 permits sampled
   - 2 staff members x 5 permits each = 10 permits sampled

2. A department that has reported issuing 1050 wastewater permits in a fiscal year with eight staff members working the Onsite Wastewater Program will have a permit sample size of 42 permits.
   - 1050 permits x 4% = 42 permits sampled
   - 8 staff members x 5 permits each = 40 permits sampled

3. A department that has reported issuing 350 wastewater permits in a fiscal year with four staff members working the Onsite Wastewater Program will have a permit sample size of 20 permits.
   - 350 permits x 4% = 14 permits sampled
   - 4 staff members x 5 permits each = 20 permits sampled

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

Section VI: Onsite Wastewater Treatment Management

Appendix B

SOIL BORING/EXCAVATION LOCATION DOCUMENTATION

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

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

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

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

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

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

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

*A reliable reference point is one of a permanent nature expected to be present at the time of absorption system installation.

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

Section VI: Onsite Wastewater Treatment Management

For soil textures, the following major soil classes of the United States Department of Agriculture (USDA) Textural Classification System (Soil Textural Triangle) and the corresponding abbreviations will be the basis for reporting.

Sand (S)
Loamy Sand (LS)
Sandy Loam (SL)
Loam (L)
Silt Loam (SIL)
Silt (SI)
Sandy Clay Loam (SCL)
Clay Loam (CL)
Silty Clay Loam (SICL)
Sandy Clay (SC)
Silty Clay (SIC)
Clay (C)

Distinctions in the sand and loamy sand classes may be made to refine the major texture classes to form the following subclasses.

Coarse Sand (COS)
Fine Sand (FS)
Very Fine Sand (VFS)
Loamy Coarse Sand (LCOS)
Loamy Fine Sand (LFS)
Loamy Very Fine Sand (LVFS)
Coarse Sandy Loam (COSL)
Fine Sandy Loam (FSL)
Very Fine Sandy Loam (VFSL)

Field descriptions of soil may also include horizon designation, color, wetness (moist, dry), structure, compaction, and presence of rock fragments.

Texture Modifiers: It is recognized that a number of modifiers can be used to further describe textured soils. Typical modifiers may include, but are not limited to, Medium, Very, Extremely, Gravelly, Cobbly, Stony, and Bouldery.

Terms used in lieu of texture: Soils not defined by the USDA Soil Textural Triangle (soil particle > 2mm or organic soils) can also be described. These may include, but are not limited to Gravel, Cobbles, Stones, Peat, Muck, Marl, Fill and Topsoil with a textural class where distinguishable.

Section VI: Onsite Wastewater Treatment Management

Appendix C

FINAL INSPECTION DOCUMENTATION
Locating Key Components

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

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

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

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

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

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

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

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

5. Other verifiable method which has been authorized based upon communication with the DEQ. As an example, a number of local health departments have requested and received authorization to utilize a Global Positioning System (GPS) and/or Geographical Information System (GIS) based technology to document the location of key components and related distance measurements.

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

Section VI: Onsite Wastewater Treatment Management

Appendix D

Failed System Evaluation
Data Collection and Submissions

For the purpose of this guidance, a failed system shall be defined as follows: **A system consists of a tank or tanks, absorption system, and associated appurtenances. A system is considered to have failed when sewage backs up into the home or structure, discharges to the ground surface, contaminates surface water or drinking water supplies, any part of the system is bypassed, the system is the source of an illicit discharge, there is an absence of an absorption system, or there is a structural failure of a septic tank or other associated appurtenances.**

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

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

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

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

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

Section VI: Onsite Wastewater Treatment Management

☐ Failed per "failure" definition ☐ Non-Failure Date: _____

DEQ Failed System Data Collection Form – Non-Residential

Address: _____ Township: _____ County: _____

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

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

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

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

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

☐ >3,000 ☐ Unknown

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

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

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

☐ Gravity Mound ☐ Dosed Mound ☐ Pressure Dosed Mound

☐ Chambers ☐ Drywells ☐ Other _____

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

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

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

☐ Organic soil, Fill soil

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

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

Probable Cause(s) of Failure:

For technical assistance, please contact Dale Ladouceur at 517-284-6534 or ladouceurd@michigan.gov

Section VI: Onsite Wastewater Treatment Management

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

☐ Other: _____

Section VI: Onsite Wastewater Treatment Management

☐ Failed per "failure" definition ☐ Non-Failure Date: _____

DEQ Failed System Data Collection Form – Residential

Address: _____ Township: _____ County: _____

Dwelling Type: ☐ Single Family ☐ Two-Family

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

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

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

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

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

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

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

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

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

For technical assistance, please contact Dale Ladouceur at 517-284-6534 or ladouceurd@michigan.gov

Section VI: Onsite Wastewater Treatment Management

Probable Cause(s) of Failure:

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

Section VI: Onsite Wastewater Treatment Management

Failed System Data Collection Form – Guidance

In October 2014, a workgroup, consisting of representatives of the Michigan Department of Environmental Quality (DEQ) and the Michigan Association of Local Environmental Health Administrators (MALEHA) On-Site Sewage and Land Use Committee, completed an effort to revise the definition of failure under Indicator 5.1. Approval of permits where the system has failed, includes retrievable documentation, when available, of the age, design, site conditions; and any other pertinent data allowing for assessment of probable reason(s) for failure and there is an annual summary of data submitted to the DEQ. The newly revised definition not only defined what a wastewater system consisted of, but also introduced new terminology and broadened the conditions that may be observed and reported by local health departments as a failure.

During the spring of 2015, the workgroup reconvened to review and discuss the newly revised definition of failure. The workgroup recognized that consistency in data collection and reporting of failure under the new definition could be improved provided there is a clear understanding of the failure conditions discussed in the revised definition of failure. As a result of the workgroup effort, this guidance for local health departments has been expanded to clarify terminology and pertinent examples of the failure conditions that may be identified in the process of evaluating an onsite wastewater system.

> **Important!** The information collected is intended to be representative of the wastewater system which has failed and requires a permit for correction. For the purpose of this guidance, a system consists of a tank or tanks, absorption system and associated appurtenances. A system is considered to have failed when sewage backs up into the home or structure, discharges to the ground surface, contaminates surface water or drinking water supplies, any part of the system is bypassed, the system is the source of an illicit discharge, there is an absence of an absorption system, or there is a structural failure of a septic tank or other associated appurtenances.

A. **Associated Appurtenances** – Examples include:
d-box (distribution box, diverter box), aeration system and chamber, added treatment devices, pumps and pump chambers, valves, effluent filters, baffles, syphons, pump vaults, floats, sweep valves and boxes, control panels, junction boxes, or similar auxiliary devices.

B. **System Bypass** – an intentional redirecting of a system component and includes advanced treatment system is bypassed, unplugged aeration device, disconnected absorption system/drain field, overflow or cheater pipe, bypass valve, pump placed into septic tank to bypass field, or other methods of system operation not functioning as designed.

C. **Illicit Discharge** – Examples include:
wastewater sent to a storm drain, wastewater sent to surface water, an open trench discharge, wastewater sent to a field tile or other system not designed for sanitary wastewater, or other physical connection to a location or system not intended to receive sanitary wastewater.

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

Section VI: Onsite Wastewater Treatment Management

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

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

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

For Residential systems: Indicate the dwelling type and size.

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

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

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

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

System Design: Indicate the type of design of the failed system when determined or if available. If no information is available, or if efforts are undertaken to locate the system at the site, such as using a tile probe or soil auger and a system is located, however the specific design cannot be determined, indicate "Unable to Determine".

Note: If it is determined that there is no system; such as a tile to a ditch or field tile or other nonexistent system, indicate "None".

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

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

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

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

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

Section VI: Onsite Wastewater Treatment Management

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

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

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

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

Section VI: Onsite Wastewater Treatment Management

DEQ Failed System Data Submission Form – Non-Residential

Calendar Year:

Local Health Department:

Total number of Non-Residential failures:

Facility Type; Totals:

- Church
- Dental/Medical
- Gas Station
- Grocery Store
- Industrial
- Multi-Family
- Office/Retail
- Restaurant
- School
- Other:_____

Estimated Flows; Totals:
(gallons per day)

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

Septic Tank Type; Totals:

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

Septic Tank Capacity – Gallons; Totals:

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

Advanced Treatment Unit; Totals Yes No
If yes, Treatment Unit Name(s): _____
_____

System Design; Totals:

- Gravity Bed
- Dosed Bed
- Pressure Dosed Bed
- Gravity Trenches
- Dosed Trenches
- Pressure Dosed Trenches
- Gravity Mound
- Dosed Mound
- Pressure Dosed Mound
- Chambers
- Drywells
- None

Section VI: Onsite Wastewater Treatment Management

☐ Other _____ ☐ Unable to Determine

System Age Totals in Years; Totals:

☐ 0 – 5 ☐ 6 – 10 ☐ 11 – 15 ☐ 16 – 20

☐ 21 – 25 ☐ 26 – 30 ☐ 31 – 40 ☐ > 40

☐ Unknown

Soil Texture Totals:

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

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

☐ Organic soil, Fill soil

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

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

Bed Size ft²; Totals:

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

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

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

Trench Size ft²; Totals:

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

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

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

Section VI: Onsite Wastewater Treatment Management

Probable Cause(s) of Failure; Totals:

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

☐ Other: _____

Section VI: Onsite Wastewater Treatment Management

DEQ Failed System Data Submission Form – Residential

Calendar Year:

Local Health Department:

Total number of Residential failures:

Dwelling Type; Totals:

☐ Single Family ☐ Two-Family

Dwelling Size; Totals:

☐ 2 Bedrooms ☐ 3 Bedrooms ☐ 4 Bedrooms ☐ >4 Bedrooms

Septic Tank Type; Totals:

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

Septic Tank Capacity – Gallons; Totals:

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

☐ >3,000 ☐ Unknown

Advanced Treatment Unit; Totals ☐ Yes ☐ No
If yes, Treatment Unit Name(s): _____

_____

System Design; Totals:

☐ Gravity Bed ☐ Dosed Bed ☐ Pressure Dosed Bed

☐ Gravity Trenches ☐ Dosed Trenches ☐ Pressure Dosed Trenches

☐ Gravity Mound ☐ Dosed Mound ☐ Pressure Dosed Mound

☐ Chambers ☐ Drywells ☐ None

☐ Other _____ ☐ Unable to Determine

Section VI: Onsite Wastewater Treatment Management

System Age Totals in Years; Totals:

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

Soil Texture Totals:

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

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

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

Bed Size ft²; Totals:

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

Trench Size ft²; Totals:

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

Section VI: Onsite Wastewater Treatment Management

Probable Cause(s) of Failure; Totals:

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

☐ Other: _____

Section VI: Onsite Wastewater Treatment Management

Appendix E

Onsite Wastewater Treatment Management Program
Self-Assessment Review Option

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

A significant component to the success of a self-assessment approach is the designation at the LHD of a key staff person or persons responsible for program training, oversight, and monitoring. They would be relied upon as the in-house expert related to program implementation consistent with the MPRs and ongoing quality assurance monitoring. Designated staff would also be expected to serve as the primary point of communication and reporting to DEQ in all matters related to accreditation specific to the Onsite Wastewater Treatment Management Program. This would include submission of annual self-assessment reports, failed system data summaries, and quarterly onsite wastewater program activity reports.

All LHDs are encouraged to utilize the self-assessment approach. However, a LHD best prepared to use this option is conducting thorough routine and ongoing quality assurance program reviews. For LHDs wishing to be authorized to utilize this approach, a written request must be submitted to DEQ for a case-by-case review. The quality assurance process, designed to meet LHD needs, is expected to be outlined by the LHD in the written request to DEQ. At the time of the scheduled accreditation review, the LHD must be prepared to discuss the specific activities being carried out.

LHDs desiring to utilize the self-assessment option are encouraged to submit their request. The self-assessment review option becomes stand-alone where a LHD has requested and been granted DEQ authorization at least 12 months prior to the scheduled accreditation review date.

Under this option, the overall accreditation review shall consist of the following elements:

- Annually, the LHD is expected to submit a program self-assessment to DEQ. The report will follow a standardized format that is available from DEQ. Annual assessments shall be transmitted each year to the DEQ in the same month as the scheduled accreditation review.
- DEQ will be responsible for providing a timely review and provide a formal response to the LHD for each self-assessment report submitted.
- As part of the ongoing self-assessment process, during the time period leading to the scheduled accreditation review by DEQ, a LHD may determine that one or more indicators are "not being met" or "met with conditions." The LHD has full discretion to:
    - Put a corrective plan of action in place, the details of which shall be communicated with DEQ.
    - Show 90 days of compliance with the plan.

Section VI: Onsite Wastewater Treatment Management

    - At the time of the scheduled accreditation review, the LHD shall receive a "Met" or "Met with Conditions" on that MPR, where DEQ verifies corrective actions have resulted in compliance.
- At the time of the scheduled accreditation review, the LHD will arrange to meet with DEQ to review and discuss the documentation outlining the Onsite Wastewater Treatment Management Program's compliance. It is anticipated that the meeting would be arranged at a time, date, and location selected by the LHD and attended by the evaluator, designated LHD quality assurance staff, and others chosen by the LHD. Discussions at that time would focus on:
    - Quality assurance activities
    - Self-assessment and compliance rating against established program standards. On or before the time of the scheduled accreditation review, the current year self-assessment document will be presented to DEQ by the LHD staff to verify that the self-assessment was completed accurately and properly.
        - The LHD will receive the rating it gave itself on any MPRs, providing DEQ verifies the rating as correct.
        - Should a LHD assess any indicators as "Not Met," which are verified at the time of accreditation review, they will be subject to the established formal accreditation Corrective Plan of Action process.
        - Should the self-assessment show an incorrect rating or a program element that was not properly or completely reviewed, that element shall be jointly reviewed with DEQ and LHD staff to determine the correct rating.
        - DEQ may review a number of the original documents assessed to determine if the self-assessment is correct and accurate.

Section VII: HIV/AIDS & STD

All Minimum Program Requirements (MPRs) and Indicators listed below must be met in order to pass the HIV/AIDS and STD section of the Accreditation Review.

Sources of authority: *The Michigan Public Health Code, MCL 333.2433, 333.5101, 333.5111, 333.5114, 333.5114a, 333.5115, 333.5117, 333.5123, 333.5127, 333.5129, 333.5131, 333.5133, 333.5201, 333.5203, 333.5204, 333.5205, 333.5207, 333.16267, 333.20169*

Mich. Admin. Code. R. 325.171-174, R. 325.177, R. 325.179b, R. 325.181

MPR 1

Provide and/or refer clients for HIV and STD screening and treatment, regardless of client ability to pay.

Reference: *The Michigan Public Health Code, MCL 333.5114a, MCL 333.5127, 333.5129, 333.5131, 333.5133, 333.5204, 333.5205, 333.5207, Mich. Admin. R. 325.177.*

Indicator 1.1

Provide HIV and STD screening and treatment services in accordance with the Michigan Public Health Code and Michigan Department of Health and Human Services (MDHHS) accreditation and current quality assurance standards.

This indicator may be met by:

- Implementing recruitment and promotional strategies designed to increase awareness and stimulate testing among high risk individuals.
- Assessing client risk for HIV and STDs.
- Providing risk reduction/prevention counseling, in accordance with current CDC guidance.
- Providing STD testing in accordance to client risk and MDHHS criteria.
- Providing HIV testing for all clients screened and/or treated for STDs.
- Providing STD testing for clients testing positive for HIV.
- Providing appropriate HIV and STD treatment or referral, according to current CDC treatment guidelines and current MDHHS policy.

Documentation Required:

- Evidence of recruitment, outreach, and promotional activities. Evidence may include, but is not limited to: press releases, flyers, posters, billboards, and/or social media posts.
- Written clinic-specific protocol and procedures for provision of HIV and STD screening and clinical services. Protocol and procedures **MUST** address:
    - Timely admission, examination, and treatment of clients presenting for HIV and STD services;
    - Assessment of client risk for HIV and STDs;
    - Criteria for prioritizing clients for HIV and STD screening;
    - Appropriate STD treatment;
    - Routine provision of HIV testing for clients screened and/or treated for STDs;
    - Provision of STD testing for clients testing positive for HIV;
    - Provision of risk reduction and prevention counseling;
    - Follow up for disclosure of test results for clients who do not complete return clinic visits.
- Evidence that all staff have received orientation/training or an annual review on clinic protocol and procedures. Evidence may include current training records, orientation checklists, or sign-in sheets.

Section VII: HIV/AIDS & STD

Evaluation Questions

- Are HIV and STD clinical and prevention services responsive to Michigan Public Health Code, MDHHS accreditation, and current quality assurance standards?
- What recruitment and promotional strategies are used to promote awareness of services and to stimulate HIV and STD testing?

Indicator 1.2

Provide court-ordered HIV and STD counseling, testing, and referral services and victim notification activities in accordance with the Michigan Public Health Code, MCL 333.5129, and MDHHS guidance.

This indicator may be met by:

Providing HIV and STD counseling, testing, and referral services on the basis of court order and for notification of victims.

Documentation Required:

- Written protocol and procedures for providing or arranging for the provision of court-ordered HIV and STD counseling, testing, and referral services and victim notification.
- Evidence that staff have received orientation and training on court-ordered testing policies and procedures. Evidence may include current training records, orientation checklists, or sign-in sheets.

Evaluation Question:

Are court-ordered HIV and STD counseling, testing, and referral services and victim notification services provided in accordance with the Michigan Public Health Code and current MDHHS guidelines?

Section VII: HIV/AIDS & STD

MPR 2

Perform activities necessary to control the spread of HIV and STD infection; conduct reporting and follow-up of HIV, AIDS, and STD cases.

Reference: *The Michigan Public Health Code, MCL 333.5111, 333.5114, 333.5129, 333.5131, 333.5133, 333.5201-5207, Mich. Admin. R. 325.172-174, 325.177, 325.179b, 325.181*

Indicator 2.1

Reporting of HIV, AIDS, and STD cases is in compliance with the Michigan Communicable Disease Rules and the Michigan Public Health Code and in accordance with current MDHHS policy.

This indicator may be met by:

- Submitting HIV and STD case reports in a timely and appropriate manner.
- Providing education and technical assistance to physicians, laboratories, and other providers regarding the submission of HIV and STD case reports.

Documentation Required:

- Locally developed protocol and procedures for completion and submission of case reports.
- Evidence that staff with responsibility for case reporting have received orientation and training to policies and procedures regarding submission of case reports. Evidence may include current training records, orientation checklists, or sign-in sheets.
- Evidence of provision of technical assistance and education to physicians, laboratories, and other providers that addresses case reporting. Evidence may include Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), meeting minutes, blast faxes, email, or other communication.

Evaluation Question:

- Are all HIV, AIDS, and STD cases reported in compliance with Michigan Communicable Disease Rules and the Michigan Public Health Code and in accordance with current MDHHS policy?
- What practices are regularly conducted to ensure timely and appropriate reporting of case reports from physicians, laboratories, and other providers?

Indicator 2.2

Confidentiality of written and electronic HIV, AIDS, and STD reports and associated patient medical records are maintained in compliance with the Michigan Public Health Code, the Health Insurance Portability and Accountability Act (HIPAA), and program standards issued by MDHHS.

This indicator may be met by:

Maintaining confidentiality of all HIV, AIDS, and STD reports, records, and data pertaining to HIV and STD testing, treatment, and reporting, pursuant to the Michigan Public Health Code, HIPAA, and program standards issued by MDHHS.

Documentation Required:

Section VII: HIV/AIDS & STD

- Locally developed written protocol and procedures that address HIV, AIDS, and STD case reporting and medical record confidentiality, including electronic medical records and laboratory management system reports, if in use.
- Evidence that staff have received and implemented appropriate orientation and training on confidentiality protocol and procedures. Evidence may include current training records, orientation checklists, or sign-in sheets.

Evaluation Questions:

- Is the confidentiality of case reports and client medical records protected pursuant to the Michigan Public Health Code, HIPAA, and program standards issued by MDHHS?
- Does the local health department have written procedures that address HIV, AIDS, and STD client privacy?

Indicator 2.3

Investigate and respond to situations involving health threats to others, pursuant to the Michigan Public Health Code.

This indicator may be met by:

Investigating and responding to situations involving health threats to others in a way that is appropriate and in accordance with the Michigan Public Health Code.

Documentation Required:

- Locally developed written protocol and procedures for investigating and responding to situations involving health threat to others.
- Evidence that staff have received and implemented appropriate orientation and training on protocol and procedures for investigating and responding to situations involving health threats to others. Evidence may include current training records, orientation checklists, or sign-in sheets.

Evaluation Question:

How does the local health jurisdiction carry out its responsibilities with regard to investigating and responding to situations involving health threats to others?

Section VII: HIV/AIDS & STD

MPR 3

Develop and maintain a system for staff-assisted referral of clients to medical and other prevention services, including mechanisms for monitoring and documenting referrals.

Reference: *The Michigan Public Health Code, MCL 333.5114a, 333.5129*

Indicator 3.1

Clients diagnosed with HIV or other STDs receive medical and other prevention services, which are responsive to their needs and in accordance with MDHHS program standards and guidelines.

This indicator may be met by:

- Facilitating referral to and linkage with prevention, treatment, and support services appropriate and responsive to client needs.
- Establishing, maintaining, and documenting linkages with health care and other community resources that are necessary and appropriate for the prevention and control of HIV and STDs and for addressing the prevention and care needs of clients.
- Providing education and technical assistance to local physicians, hospitals, other providers, and community groups to increase awareness about HIV and STDs, encourage screening for and treatment of HIV and STDs, support referral and linkages to needed services, and promote health department assisted PS.

Documentation Required:

- Written referral and linkage protocol and procedures which address:
    - Assessment and prioritization of client needs for prevention, treatment, and other services, especially as it relates to pregnant women, acute infections, co-infections, and other high risk or priority populations;
    - Provision of, or referral to, other prevention services (e.g., substance abuse disorder treatment);
    - Provision of assisted referral to specialty medical care for clients diagnosed with HIV, in order to evaluate and treat HIV infection;
    - Provision of screening for STD, especially syphilis, gonorrhea, and chlamydia, among clients diagnosed with HIV;
    - For HIV-positive clients, confirmation of referral completion. Successful linkage with partner services and medical specialty care for HIV positive clients is prioritized.
- Evidence that staff has received orientation and training on facilitated referrals. Evidence may include current training records, orientation checklists, or sign-in sheets.
- A current and comprehensive community resources referral directory. The directory should provide staff with specific information regarding services, eligibility, agency contacts, and other information necessary to make and support successful referrals.
- Evidence of provision of education and technical assistance to local providers that facilitate successful referrals, including the topic areas covered and target audience. Evidence may include MOUs, MOAs, meeting minutes, blast faxes, email, or other communication.
- Evidence of dissemination of the agency's annual report that addresses HIV, AIDS, and STD morbidity and mortality, including trends.

Section VII: HIV/AIDS & STD

Evaluation Questions:

- Are clients diagnosed with HIV and STDs successfully linked to needed medical and prevention services?
- Does the health department maintain active relationships with other providers/organizations, which are relevant and appropriate to addressing client needs for prevention, treatment, and support services?
- Are appropriate referrals made to address the needs of clients and in accordance with current MDHHS quality assurance standards?

Section VII: HIV/AIDS & STD

MPR 4

Conduct partner services (PS), by referral or through state or local staff, for HIV, syphilis, gonorrhea, and chlamydia.

Reference: *The Michigan Public Health Code, MCL 333.5114a, 333.5129, Mich. Admin. Code R. 325.173, Recommendations for Conducting Integrated Partner Services for HIV/STD Prevention (2011).*

Indicator 4.1

Individuals diagnosed with HIV, syphilis, gonorrhea, and/or chlamydia receive counseling regarding the availability of partner services (PS) and are offered assistance in notifying their sex and/or needle-sharing partners of their exposure.

This indicator may be met by:

- Providing PS, by referral or through state or local staff, which is responsive to client needs and is provided in accordance with the Michigan Public Health Code and current MDHHS standards and guidelines.
- Maintaining staffing adequate to meet PS needs.
- Maintaining relationships, for example, via memoranda of understanding/agreement (MOU/MOA), with health care providers, community-based organizations, and others that provide HIV and STD testing, in order to facilitate access to health department assisted PS among clients diagnosed with HIV and STDs.
- Maintaining timely entry of index client(s) and/or identified partner(s) documentation into the designated data system in use (i.e. Partner Services Web and MDSS), in accordance with current MDHHS policy.

Documentation Required:

- Written PS protocol and procedures that addresses:
    - Criteria and procedures for prioritizing partners and associates of index clients in accordance with current MDHHS standards and guidelines;
    - Prioritization of pregnant women, acute infections, co-infections, and other high risk or priority populations;
    - Field investigations and the proper documentation of (via Patient Field Template for PS or equivalent form);
    - Use of electronic, social media, and other communication strategies for notifying partners (including client notification of partners);
    - Provision of or referral for screening for HIV and STDs;
    - Provision of risk reduction/prevention counseling.
- Written policies to enable and support PS staff to work a flexible schedule outside the confines of the local health department.
- Evidence that staff with responsibility for PS has received orientation/training and maintains necessary certifications. Evidence may include current training records, orientation checklists, or sign-in sheets.
- Evidence of mechanisms and practices that facilitate efficient communication about PS with health care providers, community based organizations and other providers of HIV and STD testing services. Evidence may include meeting minutes, blast faxes, MOUs, or MOAs.

Evaluation Questions:

Are PS activities responsive to Michigan Public Health Code and current MDHHS standards and guidance?

Section VII: HIV/AIDS & STD

MPR 5

Provide quality assured and evidence-based HIV and STD prevention and treatment services.

Indicator 5.1

Monitor and evaluate HIV and STD prevention and treatment services.

This indicator may be met by:

- Conducting routine, data-driven monitoring and evaluation activities.
- Conducting routine quality assurance of HIV and STD prevention and treatment services responsive to MDHHS quality assurance standards and guidelines.

Documentation Required:

- Evidence that data are routinely applied to program monitoring and evaluation activities. Examples include: use of trend data to trigger adjustment in outreach activities; case conferencing that allows for coordinated prevention activities; quality improvement projects utilizing the Plan, Do, Study, Act cycle; development of a LHD strategic plan; or use of county, state, or national data to inform programmatic decisions.
- Written protocol and procedures for quality assurance activities associated with provision of HIV and STD prevention and treatment services. Protocol and procedures must address methods to regularly address staff competency and performance.
- Evidence of use of multiple strategies to conduct agency-developed quality assurance.
- Evidence that staff has participated in quality assurance activities.
- Evidence that staff and supervisors have participated in training and professional development activities designed to improve their capacity to provide high quality HIV and STD prevention and treatment services. Evidence may include current training records, orientation checklists, or sign-in sheets.
- Evidence of completion and timely submission of monthly STD clinic medication log, pursuant to guidance issued by MDHHS for 340B program requirements.
- Evidence of completion and timely submission of quality assurance reports, pursuant to guidance issued by MDHHS, including rapid test quality assurance logs, STD Program Quarterly Activity Report, and STD Quarterly Medication Inventory Report.

Evaluation Questions:

Are quality assurance activities routinely conducted and responsive to MDHHS issued quality assurance standards and guidelines?

Section VIII: Vision

MPR 1

The local health department shall provide vision screening services for preschool children between the ages of 3 and 5 years at program centers

Reference: *Michigan Administrative Code, R 325.13094 (1).*

Indicator 1.1

There is documentation that children between the ages of 3 and 5 years were scheduled for and received vision screenings in preschool, Head Start, and child care programs.

This indicator may be met by:

- A written policy or program plan articulating procedures for vision screening children between the ages of 3 and 5 years; **AND**
- An agency calendar or appointment book documenting vision technician assignments and/or responsibilities for the past year; **AND**
- A list of preschool, Head Start, and child care programs scheduled to receive vision screening services for the current year; **AND**
- Local health department quarterly Reporting Forms (DCH-0604) indicating the number of preschool children screened, passed, failed, referred, and receiving care.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 2

The local health department shall provide vision screening services for school-age children in grades 1, 3, 5, 7, & 9 or in grades 1, 3, 5, & 7, and in conjunction with driver training classes at schools (public, private, charter, etc.)

Reference: *Michigan Administrative Code R 325.13094 (2).*

Indicator 2.1

Program activity reports and statistics document the provision of vision screening in public and private schools for all estimated children in need (e.g., total number of children in grades1 ,3, 5, 7, and 9)

This indicator may be met by:

- A chart or schedule documenting agency vision technician assignments and/or responsibilities for the current year; **AND**
- A written policy or program plan articulating the level of frequency for vision screening school-age children; **AND**
- Local Health Department Quarterly Reporting Forms (DCH-0604) indicating the number of school-age children screened, passed, failed, referred, and receiving care since the last accreditation site visit.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 3

The local health department shall assure that vision screening is conducted in accordance with the Michigan Department of Health and Human Services (MDHHS) Vision Technician's Manual (latest edition).

Reference: *Michigan Administrative Code R 325.13092.*

Indicator 3.1

Appropriate screening equipment and supplies are in working order and used in the screening of preschool, ages 3-5 years, and school-age children.

This indicator may be met by:

- The local health department has on file the MDHHS Vision Technician Screening Manual (latest edition); **AND**
- Preschool supplies and equipment used by vision technicians including a tape measure, training cards, the LEA Symbols flash card acuity test, and a Stereo Butterfly Test for the screening of preschool children for binocular and monocular visual acuity, two-line difference acuity, and near stereopsis; **AND**
- School-age supplies and equipment used by vision technicians including a functioning stereoscopic instrument for the screening of school-age children for monocular visual acuity, far phoria, and two-line difference acuity, black wooden "E", or comparable orientation "E", and the plus lens test.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 4

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

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

Indicator 4.1

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

This indicator may be met by:

- DCH-0503 Room Summary Forms and DCH-0503P Preschool Daily Report Forms (or equivalents) confirming follow-up information on children referred to an eye care practitioner, and sample parent letters for inspection to confirm agency process for follow-up of children referred to an eye care practitioner

Documentation Required:

See above.

Evaluation Question:

None

Indicator 4.2

Documentation demonstrates that a child referred for examination or treatment has received the recommended services.

This indicator may be met by:

- DCH-0503 Room Summary Forms and DCH-0503P Preschool Daily Report Forms (or equivalents), or letters confirming the follow-up of children referred to an eye care practitioner

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 5

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

Reference: *Michigan Administrative Code R 325.13093.*

Indicator 5.1

All vision technicians have been trained in accordance with curriculum approved by MDHHS, all vision technicians have attended an MDHHS approved vision technician workshop once in the last two years.

This indicator may be met by:

- Vision training certificates are on file confirming that technicians have participated in the approved MDHHS training course to become qualified to screen preschool and school-age children; **AND**
- Workshop certificates are on file confirming that technicians have participated in the approved MDHHS vision technician workshop once in the last two years; **AND**
- Appraisal forms to confirm the participation of the vision technicians in the State-developed Technician Assessment Program (TAP), where preschool screening procedures are observed and evaluated by an outside monitor with a minimum of at least 5 children, ages 3-5 years; **AND**
- Appraisal forms to confirm the participation of the vision technicians in the State-developed TAP, where school-age screening procedures are observed and evaluated by an outside monitor with a minimum of at least 5 children in grades 1,3,5,7 and 9.

Documentation Required:

See above.

Evaluation Question:

None

Section VIII: Vision

MPR 6

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

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

Indicator 6.1

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

This indicator may be met by:

- Public announcements and media advertisement publicizing opportunities for scheduling preschool children for vision screening at local health departments.
- Documentation of public bulletins and public service announcements, since the last accreditation site visit, that includes language indicating free vision testing is available.
- An annual timetable for the purpose of notifying the public of vision screening dates, locations, and procedures for scheduling preschool children, ages 3 through 5 years, and school-age children in grades 1, 3, 5, 7, and 9, or in conjunction with driver's training.

Documentation Required:

See above.

Evaluation Question:

None

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload and Navigation-Only Services - Program Management

MPR 1

Coordinate with MDHHS a scheduled review of minimum program and reporting requirements.

References: *PL 101-354, Section 1501 (a)(6); CDC Administrative Guidance; CPBC provision, 2015 CDC Navigation Services Only Policy*

Indicator 1.1

Requirements to provide assistance to insured, underinsured, and uninsured eligible women aimed at identifying and addressing barriers which would impede access to receiving timely and appropriate breast and/or cervical cancer screening, diagnosis and/or treatment services.

This indicator may be met by:

There must be evidence that the local health department is continuously meeting the Centers for Disease Control and Prevention (CDC) and program requirements in delivering both caseload and navigation services to eligible program women.

Documentation Requested:

None, specifically, for this indicator. This indicator is met as a result of sending required documentation to MDHHS for review.

Evaluation Question:

None

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload Services - Program Management

MPR 2

Assure that an accurate and integrated system of fiscal management is maintained on-site for health departments providing and coordinating 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 procedure for communicating between local health department staff and BCCCNP providers is established to enable accurate and timely processing of clinical service data, and to assure adequate provider training and support in resolving clinical and billing issues.

This indicator may be met by:

All of the following:
The local health department has a written policy/procedure for describing how they:

- Retrieve clinical service data from each BCCCNP subcontracted provider/clinic or has access to client clinical service and billing data via an Electronic Medical Record.
- Verify the accuracy of all clinical and non-clinical client data prior to entering it in the Michigan Breast and Cervical Information System (MBCIS).
- Communicate important program information/changes to BCCCNP staff at the local health department and subcontracted provider staff.

Documentation Requested:

- 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.
- Evidence of correspondence/emails/memos/phone calls/meeting minutes to providers within the last 6 months.

Evaluation Questions:

- Is there a written policy outlining the procedures identified under the "This indicator may be met by" section of Indicator 2.1? Has the local health department provided the specified documentation required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload Services - Outreach/Recruitment

MPR 3

Establish a media/promotion plan targeted to eligible women that promotes BCCCNP screening and diagnostic caseload services.

Establish a process working with medical and community providers in identifying and recruiting women eligible to receive BCCCNP caseload services based on program criteria (age, income, and insurance status) as defined by CDC and federal law.

References: *PL 101-354, 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*.

* Priority populations for caseload services are defined as uninsured and underinsured women age 40-64, requiring breast/cervical cancer screening, diagnostic, and/or treatment services.

This indicator may be met by:

The local health department maintains on file evidence that recruitment and promotion efforts are planned and implemented by itself or in conjunction with other organizations through development of public service announcements, media campaigns, patient brochures, public awareness flyers, semi-annual newsletters, and information packets.

Documentation Requested:

- Examples of promotional media aimed at identified priority populations.
- Documentation of collaboration with community/other healthcare organizations representing target populations (shown through meeting minutes, phone calls, emails, written correspondence, etc.).

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 3.2

Establish relationships with medical and community providers to assist agency in recruiting BCCCNP eligible women based on program criteria (age, income, and insurance status). This includes women from the following categories:

1. Underinsured women (139% - 250% FPL) identified with an abnormal breast or cervical cancer screening result and require diagnostic follow-up but have a high insurance deductible/co-pay.
2. Uninsured women (≤ 250% FPL) requiring breast and/or cervical screening/diagnostic services.
3. Women age 50-64 (percentage recruited is based on CDC's program criteria).
4. Women never or rarely screened for cervical cancer (CDC defines never or rarely screened as the number of NEWLY enrolled women requiring caseload services who have never had a Pap test or not had a Pap test in >/= 5 years. Does not apply to women previously screened in the program or only receiving diagnostic services in the program).

This indicator may be met by:

A plan exists to recruit the target populations of women as defined above into the local BCCCNP. The local coordinating agency must describe, in writing, how they collaborate with medical and community providers to:

- Identify underinsured and uninsured women eligible to receive caseload services in the program.
- Identify and recruit priority women (age 50-64) to comply with caseload ratios determined by MDHHS and CDC.
- Identify and recruit women never or rarely screened for cervical cancer in the program as defined by CDC.

Documentation Requested:

- WRITTEN procedure/plan describing agency's process for identifying and recruiting target Populations, as described under the "This indicator may be met by" section of Indicator 3.2.

Evaluation Questions:

- Has the local health department provided the documentation requested?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload Services – Clinical Care Delivery

MPR 4

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 4. 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.

This indicator may be met by:

The local coordinating agency can produce a copy of a written policy/procedure describing:

- Process for ensuring all contracted providers receive and review the current BCCCNP medical protocol.
- Plan of action to implement when a provider does not follow the medical protocol.

Documentation Required:

- 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.

Evaluation Question:

- Has the local health department provided the specified documents required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 4.2

The local coordinating agency provides evidence describing their role in assisting women diagnosed with cancer in the program to obtain needed treatment services.

This indicator may be met by:

- The local coordinating agency is able to produce a policy/procedure describing the process for assisting women diagnosed with breast or cervical cancer with obtaining cancer treatment services.

Documentation Required:

- Written policy/procedure describing the process for assisting program women with obtaining cancer treatment.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload Services – Clinical Care Delivery

MPR 5

Obtain each woman's informed consent at the beginning of each annual screening cycle.

References: *State Advisory Committee Policy (WCDC).*

Indicator 5.1

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/diagnostic 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.

This indicator may be met by:

- Review of agency's informed consent to assure items in # 1-4 above are included.

Written policy/procedure describing the process for:

- Determining a client's eligibility for the program
- Assuring completion of all appropriate program paperwork by the client
- Obtaining (and re-verifying) the client's informed consent on an annual basis
- Scheduling the appropriate screening and/or diagnostic services
- Describing the agency's availability to assist with seeking follow-up services at the time of initial screening and again, at the time that a woman is informed of follow-up needed for an abnormality

Evaluation Questions:

- Has the agency provided a copy of their informed consent along with a written process describing requirements as outlined under the "This indicator may be met by" section of Indicator 5.1?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload Services – Program Reimbursement of Clinical Services

MPR 6

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

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

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 6.1

Each client's eligibility to receive caseload services reimbursed by the program is reviewed at the time of enrollment. For underinsured clients, a front and back copy of each insured client's insurance card is made at the time of enrollment.

This indicator may be met by:

The local health department maintains on file:

- A front and back copy of all underinsured clients insurance cards are copied upon enrollment.
  - NOTE: a print-out of the client's insurance eligibility from an online service, such as CHAMPS, is not acceptable.

- Written evidence of the local health department's process/procedure for obtaining a copy of client's insurance card and for billing client's insurance first prior to reimbursing for BCCCNP services.

Documentation Requested:

- Client chart records, and copy of front and back of the insurance cards for all insured clients documenting insurance information for services provided in May of the last fiscal year ended (or, if no insured clients seen in May, most recent month in which insured clients were served).

Evaluation Questions:

- Do specified chart records / insurance records of the last fiscal year ended (or, if no insured clients seen in month specified, most recent month in which insured clients were served) show evidence that each client's insurance information is accurately recorded at the time of enrollment. (e.g., copy of insurance card, accurately documented on the client enrollment form, etc.)?
- Has the local health department provided a policy statement stating that the agency follows the BCCCNP Caseload Services policy for enrolling underinsured women in the program?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 6.2

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.

*Note –Indicator 6.2 does not apply to instances of one-time use of providers currently contracted with other local coordinating agencies.

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.

This indicator may be met by:

The local health department maintains on file a contract or letter of agreement with each BCCCNP clinical service provider, stating that the provider:

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

Documentation Requested:

- All signed, last fiscal year ended BCCCNP clinical service provider contracts or letters of agreement should be made available to reviewers. Reviewers will request a sample of signed BCCCNP clinical service provider contracts or letters of agreement from the previous fiscal year.

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Evaluation Question:

- Does each subcontracted physician/hospital/laboratory arrangement, in the sample selected by the reviewers, reflect the providers' agreement to accept the BCCCNP reimbursement rate as payment in full for each BCCCNP authorized procedure?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 6.3

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.

This indicator may be met by:

The local coordinating agency maintains on file:

- Agreements or communication methods documenting providers are provided a copy of the BCCCNP Unit Cost Reimbursement Rate Schedule which indicates the maximum rates for BCCCNP screening and diagnostic services.

Documentation Required:

- Copies of any communications with providers documenting all updates of BCCCNP Unit Cost Reimbursement Rate Schedules during the last fiscal year ended.

Evaluation Question:

- Has the local coordinating agency provided documentation of all updates to BCCCNP Unit Cost Reimbursement Rate Schedules during the last fiscal year ended?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Navigation-Only Services - Outreach/Recruitment

MPR 7

Establish a network of medical and community providers that will assist the agency in:
1. Identifying insured eligible women (<250% FPL) requiring assistance (navigation-only services) in accessing the health care system to obtain needed breast/cervical cancer services through their insurer.
2. Identifying resources available for resolving barriers that may impede the woman from receiving breast/cervical cancer screening services.

References: *PL101-354, Sections 1501 (a)(3) and 1504 (a); CDC Administrative Guidance. 2015 CDC Navigation-Only Services Policy*

Indicator 7.1

A written outreach/recruitment plan is in place listing strategies to be implemented by the agency to identify eligible women requiring navigation-only services only through the BCCCNP. A list of resources available for resolving barriers is included as part of this plan.

This indicator may be met by:

The local health department has a written plan that describes strategies for identifying women eligible to receive navigation-only services and a list of resources to assist them, if needed, in overcoming barriers.

Documentation Requested:

- Written plan describing the information identified under the "This indicator may be met by" section of Indicator 7.1.

Evaluation Question:

- Has the local health department provided the specified documentation required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Caseload and Navigation-Only Services - Documentation of Data

MPR 8

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

References: *PL 101-354, Section 1501 (a)(6); CDC Administrative Guidance; CDC Performance Indicators, BCCCNP Caseload Services and Navigation-Only Services Policies.*

Indicator 8.1

1. A tracking system is used to monitor all caseload services AND navigation-only services provided to eligible program women; **AND**
2. Written process/procedure is in place that describes a plan for utilizing the monthly "Abnormal Result" report and other specific agency reports through a program-approved reporting tool to identify caseload services provided to women with abnormalities requiring immediate follow-up according to the BCCCNP Medical Protocol; **AND**
3. Written process/procedure is in place describing a plan for tracking insured women requiring navigation-only services.

This indicator may be met by:

1. Caseload services data from the Michigan Breast and Cervical Information System (MBCIS) and the "Abnormal Result" report are used to monitor and guide the care provided to every enrolled uninsured/underinsured woman appropriately; **AND**
2. Navigation-Only services data from MBCIS and agency specific reports are used to monitor completion of navigation-only services (receipt of screening/diagnostic/ and/or treatment services) provided to insured women; **AND**
3. Written process/procedure is in place that describes the plan for reviewing specified agency reports to monitor care provided to women receiving caseload or navigation-only services.

Documentation Requested:

- Identification of lead program-approved reporting tool user at the agency responsible for reports.
- Written process/procedure identifying how the agencies monitors care provided to women receiving caseload services or navigation-only services.

Evaluation Question:

Has the local health department provided the specified documentation required for the evaluation?

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 8.2

For clients receiving caseload services:
Evidence is available for clients 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.

This indicator may be met by:

Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received appropriate care according to the CDC Performance Indicators; **OR**

- Have demonstrated at least a 10% improvement towards achievement of the CDC Performance Indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None. MDHHS/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

None

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 8.3

Review of CDC Completeness Performance Indicator data in the 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)

This indicator may be met by:

Computer records of identified women requiring breast and/or cervical diagnostic and treatment services based on abnormal breast/cervical screening results requiring immediate follow-up indicate that women:

- Have received follow-up care according to the CDC Performance Indicators; **OR**

- Have demonstrated at least a 10% improvement towards achievement of the CDC Performance Indicators from previous year's chart reviews. The 10% improvement will be evaluated based on evidence of implementation of the local health department's quality improvement plan/process to address plan for achieving CDC Performance Indicators.

Documentation Required:

None. MDHHS/Cancer Prevention and Control Section reviews off-site.

Evaluation Question:

None

Section IX: Breast and Cervical Cancer Control Navigation Program (BCCCNP)

Indicator 8.4

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

This indicator may be met by:

The local health department must provide a signed copy of the Secured Application User Agreement Access form. The copies must match the MBCIS Secured Application User Agreement Access Forms on file at MDHHS/Cancer Prevention and Control Section.

Documentation Required:

A signed copy of the Secured Application User Agreement Access form for all MBCIS users.

Evaluation Question:

Do all individuals with access have a Secured Application User Agreement Access form on file at MDHHS?

Section X: Family Planning

MPR 1

Provide a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including infertility services and services for adolescents).

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(1)*

Indicator 1.1

- Broad Range of contraceptive methods. (9.8; 18. A; 21; 21.A; 21.1 B., C., D.; 19.C; 21.G.1. a-l; 21.G; 21.G.2; 21.G; 21.G.7; 20.A.; 29.D.2.e; 29B.7)

See Michigan Title X Family Planning Standards & Guidelines

To fully meet this indicator:

- The agency provides a broad range of effective Food and Drug Administration (FDA) approved family planning methods and services including natural family planning methods, and temporary and permanent contraception either on-site or by referral. **(9.8; 18. A)**
- Written protocols and operating procedures are in place and available at each clinical site. **(21; 21.A)**
- Methods provided and for which written protocols are in place, include: **(21.1 B., C., D.)**
  - Reversible Contraception
    - Hormonal contraceptives
      - at least 2 delivery methods combined hormonal contraceptives on site
      - at least 1 method progestin-only hormonal contraceptive on site
      - at least a second progestin-only method available on site within 2 weeks
    - Condoms (at least male condoms)
    - At least one type of long acting reversible contraceptive (LARC) method is provided, either on site or by paid referral.
    - Education materials and information regarding all methods including:
      - Hormonal contraceptives
      - Abstinence
      - Natural family planning (Fertility awareness)
      - Barrier methods
      - LARCs (Intrauterine devices or Implants)
      - Sterilization
      - Emergency contraception
  - Emergency Contraception
    - Emergency Contraception education and referral is provided to all female clients
    - A written protocol is in place
  - Permanent Contraception (Sterilization)
    - Education and information regarding sterilization is provided for both male and female clients, if indicated
    - The agency has a list of community providers where clients can be referred for sterilization (Paid referrals for sterilization are not required)

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Section X: Family Planning

  - All federal regulations on sterilization are met, if the procedure is performed by the agency
- Individual client education and counseling is offered and/or provided prior to the client making an informed choice regarding family planning services. **(19.B. C.)**
- Clients (adolescents or adults) who are undecided on a contraceptive method are informed about all methods that can be safely used based on the Centers for Disease Control and Prevention (CDC) Medical Eligibility Criteria. **(21.G)**
- Client education and information about contraceptive methods is medically accurate, balanced, and provided in a nonjudgmental manner. **(21.G)**
- Client education about contraceptive methods that can be safely used includes: **(21.G.1. a-i)**
  - Method effectiveness
  - Correct and consistent use of the method
  - Benefits and Risks
  - Potential side effects
  - Protection from STDs
  - Starting the method
  - Danger signs
  - Availability of emergency contraception
  - Follow-up visits
- Documentation of contraceptive education and counseling must be in the client's medical record**. (21.G; 21.G.2)**
- The client's voluntary general consent is obtained prior to receiving any clinical services. All consents are included in the client's record. **(20.A.; 29.D.2.e)**
- An informed consent for the procedure is obtained prior to inserting an IUD or implant. **(21.G.7)**
- Medical records of transfer clients receiving prescriptive methods contain: **(29B.7.)**
  - A general consent for services
  - A completed client history that has been reviewed
  - A documented blood pressure (BP), if the client desires to continue a combined hormonal method
  - Documentation of the prescription in the client record method

Documentation Required:

- Protocol and operating procedures manual specific to all contraceptive methods services
- General consent for services
- Educational materials for all methods
- Access to clients' records
- Consent forms used for procedures

Evaluation Questions:

None

Indicator 1.2

Basic Infertility Services. (25; 25.C; 25.D; 25.F)

See Michigan Title X Family Planning Standards & Guidelines

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Section X: Family Planning

To fully meet this indicator:

- The agency offers basic infertility services to women and men desiring these services. The agency has written protocols and procedures that are current and consistent with national standards. **(25)**
- Basic infertility protocols include:
  - Basic Infertility services for women including:
    - Medical history
    - Physical examination as indicated
    - Counseling
    - Appropriate referrals. **(25.C, F.)**
  - Basic Infertility services for men including:
    - Medical history
    - Physical examination as indicated
    - Counseling
    - Appropriate referrals. **(25.D, F.)**

Documentation Required:

- Protocol and Operating procedure manual
- Infertility educational materials
- Referral services provider listing

Evaluation Questions:

None

Indicator 1.3

Services for Adolescents. (8.4.5; 8.4.5.A; 9.8; 9.12; 9.12.A, B; 10.1.D; 21. G; 21.H; 21.H.2; 21.H.3; 17

To fully meet this indicator:

- The agency provides family planning and related preventive health services to adolescents. **(9.8; 17)**
- The agency does not require written consent of parents or guardians for the provision of services to minors nor notify parents or guardians before or after a minor has requested and received family planning services. **(10.1 D)**
- The agency provides confidential services to adolescents and observes all state laws regarding mandated reporting. **(21.H.2)**

Adolescent clients who are undecided on a contraceptive method are informed about all methods that can safely be used based on CDC Medical Eligibility Criteria. **(21.G)**

- Comprehensive information is provided to adolescent clients about how to prevent pregnancy. **(21.H)**
- Written protocols and operating procedures are in place that address adolescent counseling, including:
  - Encouraging family participation in the decision of minors to seek family planning services **(9.12.A; 21.H.3)**
  - Counseling on how to resist attempts to be coerced into sexual activities **(9.12.A)**
  - Informing adolescents that services are confidential, and that in special cases (e.g. child abuse) reporting is required **(21.H.2)**
  - Education and counseling is documented in the client record **(21.G)**

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Section X: Family Planning

- Agency has written policies and procedures to comply with state laws requiring reporting of child abuse, child molestation, sexual abuse, rape, or incest. **(9.12)**
- Confidentiality is never invoked to circumvent reporting requirements for child abuse and neglect. **(9.12.B)**
- The agency charges minors obtaining confidential services based on the resources of the minor and not on the family income. **(8.4.5)**
- The agency does not have a policy of no fees, flat fees, or any different fee schedule for adolescents than the fee schedule used for other populations served**. (8.4.5.A)**

Documentation Required:

- Protocols and operating procedures that address adolescent services and adolescent counseling
- Access to adolescent records to review documentation
- Educational materials that address contraceptives and adolescent services

Evaluation Questions:

None

Section X: Family Planning

MPR 2

Provide services without subjecting individuals to any coercion to accept services, or to employ, or not to employ any particular methods of family planning. Acceptance of services must be solely on a voluntary basis and may not be made a prerequisite to eligibility for, or receipt of, any other services, assistance from or participate in any other program.

References: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(2)*

Indicator 2.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.1; 8.1.A,B,C,D
- 20. A

To fully meet this indicator:

- The agency providing family planning services assures that services will be provided to clients:
  - On a voluntary basis **(8.1)**
  - Without coercion to accept services or any particular method of family planning **(8.1.A; 20.A)**
  - Without making acceptance of services a prerequisite to eligibility for any other service or assistance in other programs **(8.1.B)**
- The agency general consent for services includes that services are provided on a voluntary basis, without coercion to accept services, and without prerequisite to accept any other service**.(8.1.D; 20.A)**
- Staff have been informed that they may be subject to prosecution under federal law if they coerce or endeavor to coerce any person to accept abortion or sterilization. **(8.1.C)**

Documentation Required:

- Policy and operating procedures that address voluntary participation without coercion, eligibility, or prerequisite.
- Agency general consent for services form
- Documentation that staff has been informed of the possibility of prosecution if they coerce any client to accept abortion, sterilization, or any specific method of contraception.

Evaluation Questions:

- Are there written policies in place that reflect that all services are voluntary, provided without coercion, and provided without making acceptance of services a prerequisite to eligibility for any other service or assistance in other programs?
- Does the agency general consent for services include that services are voluntary, provided without coercion, and provided without a prerequisite to accept any other service?

Section X: Family Planning

MPR 3

Provide services in a manner which protects the dignity of the individual.

References: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(3)*

Indicator 3.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.3.7.C
- 8.5.2
- 9.2
- 9.12.B
- 10.1.A,B,C
- 10.2
- 10.3
- 10.4
- 13.4; 13.4 A
- 13.5; 13.5.C
- 21.H.2
- 19.A.1-7
- 29.D.3a-f

To fully meet this indicator:

- The agency provides services in a manner that protects the dignity of each individual. **(9.2)**
- Has written policy and/or operating procedures to assure the dignity and respect for cultural and social practices of the service area population. **(9.2; 8.5.2)**
- Service delivery to all clients includes the following: **(19.A. 1-7)**
  - Assuring clients are treated courteously and with dignity and respect
  - Addressing the needs of diverse clients
  - The opportunity to participate in planning their own medical treatment
  - Encouraging clients to voice any questions or concerns they may have
- Client confidentiality is assured by the following: **(10.1. A., B., C.; 19.A.3; 29.D.3a)**
  - A confidentiality assurance statement appears in the client's record
  - Confidentiality is assured in agency policy and procedures
  - All agency personnel assure confidentiality, such as a confidentiality statement
- The clinic has safeguards to provide for the confidentiality and privacy of the client as required by the Privacy Act. **(10.1,10.2; 29.D.3.a-f)**
- A system is in place to keep client records confidential. **(29.D.3)**
- The agency does not disclose client information without the client's consent, except as required by law or as necessary to provide services. **(10.2; 29.D.3.c)**
- The agency has policies and procedures to assure compliance with mandatory reporting and human trafficking laws. **(8.3.7.C.; 9.12.B; 10.4; 13.5; 13.5.C; 21.H.2.)**
- Information collected for reporting purposes is disclosed only in summary or statistical form **(10.3; 29.D.3.d)**

Section X: Family Planning

- Upon request, transferring clients are provided with a copy or summary of their record to expedite care. **(29.D.3.e)**
- Upon request, clients are given access to their medical record. **(29.D.3.f)**
- The agency obtains Michigan Department of Health and Human Service (MDHHS) approval prior to conducting any clinical or sociological research using Title X clients as subjects. **(13.4; 13.4 A)**

Documentation Required:

- Policy and Procedure Manuals
- Client records

Evaluation Questions:

- Do policies and procedures address treating clients with dignity and respect for diverse cultural and social practices, and assure client confidentiality?
- Are policies and procedures in place to comply with mandatory reporting requirements?

Section X: Family Planning

MPR 4

Provide services without regard to religion, race, color, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(4)*

Indicator 4.1

See Michigan Title X Family Planning Standards & Guidelines

- 9; 9.3
- 13.1; 13.1.C. 4
- 13.5.A.1,2
- 19.D

To fully meet this indicator:

- The agency has written policies and procedures on non-discrimination in providing services, including: Race, Religion, Color, National origin, Creed, Handicapping condition, Sex, Number of pregnancies, Marital status, Age, Sexual orientation, and Contraceptive preference. **(9; 9.3)**
- The agency complies with [45 CFR Part 84], so that, when viewed in its entirety, the agency is readily accessible to people with disabilities **(13.1)**
- The local agency has a written plan including all required components to ensure meaningful access to services for persons with limited English proficiency **(13.1)**
- Consent forms are language appropriate for Limited English Proficiency (LEP) clients or are translated by an interpreter. **(13.1.C 4; 19.D)**
- The agency complies with the Office of Population Affairs FPAR requirements, including a system to assure accurate collection of race and ethnicity data (FPAR Tables 2 and 3) **(13.5.A.1,2)**

Documentation Required:

- Non-discrimination policy
- Copy/location of agency's posted or distributed non-discrimination policy
- LEP plan
- Consent forms written in languages other than English, as appropriate
- Client demographic data form

Evaluation Questions:

- Are facilities accessible to individuals with disabilities including:
  - Entrance ramps are clearly marked and easily accessible?
  - Toilets accessible to the handicapped?
  - Handicapped parking?
- Does the LEP plan include:
  - A statement of agency's commitment to provide meaningful access to LEP individuals?
  - A statement that services will not be denied to clients because of LEP?

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Section X: Family Planning

- A statement that clients will not be asked or required to provide their own interpreter?
- Language Assistance, oral interpretation, and/or written translation?
- Staff training?
- Providing notice to LEP persons?
- Routine updating of the LEP plan?

- Does the agency have a process to assure accuracy of race and ethnicity data in its client data system to assure accurate data for the FPAR?

Section X: Family Planning

MPR 5

Not provide abortion as a method of family planning. Offer pregnant women the opportunity to be provided information and counseling regarding each of the following options: (A) Prenatal care and delivery; (B) Infant care, foster care, or adoption; and (C) Pregnancy termination.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(5) and (i)*

Indicator 5.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.2; 8.2 A.
- 9.10; 9.11
- 24; 24 A-G

To fully meet this indicator:

The agency must:

- Not provide abortion as a method of family planning and have a written policy that no Title X funds are used to provide abortion as a method of family planning. **(8.2; 8.2A)**
- Provide pregnancy diagnosis and counseling to all clients in need of this service. **(9.10; 24)**
- Have written protocols and procedures to offer pregnancy diagnosis and counseling services that are current and consistent with national standards of care. **(24)**
- Pregnancy diagnosis services include the following: **(24.A)**
    - General consent for services
    - Reproductive Life Plan discussion
    - Pertinent medical history
    - Zika risk assessment
    - Testing with highly sensitive pregnancy test
    - Test results given to the client
    - Counseling and referral resources as appropriate
    - Chlamydia testing offered to females <25 years of age and as indicated by risk factors for women 25 years old or older
- If a pregnancy test is positive, and if ectopic pregnancy or other pregnancy abnormalities are suspected, immediate referral for diagnosis and treatment must occur. **(24.B)**
- The agency offers pregnant women information and counseling regarding the following options: **(9.11; 24.C)**
    - Prenatal care and delivery
    - Infant care, foster care, or adoption
    - Pregnancy termination
- If requested to provide pregnancy options information and counseling, the agency must provide neutral, factual information, and non-directive, unbiased counseling on each of the options and referral upon request, except with respect to any option(s) about which the pregnant woman does not wish to receive such information and counseling. **(9.11; 24.D)**
- For clients considering/choosing to continue the pregnancy, a referral for prenatal care and initial prenatal counseling must be provided. (**24.G)**

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Section X: Family Planning

- For clients with a negative test, appropriate information about family planning services must be offered. **(24.H,I)**

Documentation Required:

- Protocol and operating procedures for pregnancy diagnosis and counseling
- Client medical records
- Pregnancy test consent form
- Educational materials related to pregnancy
- Current referral listing of providers

Evaluation Questions:

- Is the referral list current and does it include a full range of providers for pregnancy care?
- Is Chlamydia testing incorporated into pregnancy testing visits?
- Are Zika risk assessment, education/prevention strategies, and appropriate screening referral incorporated into pregnancy test visits?

Section X: Family Planning

MPR 6

Provide that priority in the provision of services will be given to persons from low-income families.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(6)*

Indicator 6.1

See Michigan Title X Family Planning Standards & Guidelines

- 4
- 5
- 8.4
- 9.1

To fully meet this indicator:

- The agency has written policies and/or procedures to assure that no patient is denied services or is subject to any variation in quality of services because of inability to pay **(8.4)**
- Low-income and high priority populations to be served are identified in the agency's annual plan. **(4;5)**
- Have policy and/or procedures to ensure that low-income clients are given priority to receive services **(9.1)**

Documentation Required:

- Sliding fee scale
- Non-discrimination policy for ability to pay
- Policy and/or Procedures to assure that low-income clients are prioritized
- Agency or MDHHS Family Planning brochure describing eligibility and services

Evaluation Questions:

None

Section X: Family Planning

MPR 7

Provide that no charge will be made for services provided to any persons from a low-income family (at or below 100% of the Federal Poverty Level) except to the extent that payment will be made by a third party (including a government agency) which is authorized to or is under legal obligation to pay this charge.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(7)*

Indicator 7.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.4.1; 8.4.1.A
- 8.4.9
- 13.5.A.1,2

To fully meet this indicator:

The local agency must have written policies and procedures for billing and collecting client fees; these policies must include the following:

- Clients whose documented income is at or below 100% of the federal poverty level are not charged; although the agency bills all third parties authorized or legally obligated to pay for services. **(8.4.1)**
- The agency relies on client self-report of income for determining eligibility for a discount, except where the agency may use income verification data provided by the client because of participation in other programs operated by the agency. **(8.4.1.A)**
- Voluntary donations from clients are permissible; however, clients are not pressured to make donations and donations are never a prerequisite to provision of services or supplies. **(8.4.9)**
- The agency complies with the Office of Population Affairs FPAR, including having a system to assure accurate collection of client income data (Table 4). **(13.5A.1,2)**

Documentation Required:

- Client records showing eligibility for discount for services/billing sheets
- Proportional sliding fee schedule established using current DHHS Poverty Guidelines
- Written agency policy and procedures for charging, billing, and collecting client fees
- Client demographic data collection system

Evaluation Questions:

- Does the agency have a system to assure that client data on its data system are accurate for FPAR?

Section X: Family Planning

MPR 8

Provide that charges will be made for services to persons other than those from low-income families in accordance with a schedule of discounts based on ability to pay, except that charges to person from families whose annual income exceeds 250 percent of the levels set forth in the most recent Poverty Guidelines will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(8)*

Indicator 8.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.4
- 8.4.2; 8.4.2.A; 8.4.2.B
- 8.4.3
- 8.4.4; 8.4.4.A
- 8.4.8; 8.4.8.A

To fully meet this indicator:

- The local agency must have written policies and procedures for billing and collecting client fees. **(8.4)**
- The agency has a schedule of discounts for individuals with family incomes between 101% and 250% of the federal poverty level that is proportional and based on current federal poverty levels. **(8.4.2)**
- Individual eligibility for a discount must be documented on the client's record/file. **(8.4.2.A)**
- The agency has the capacity to provide a bill for the services provided to a client who requests a bill. **(8.4.2.B)**
- Fees are waived for individuals with family incomes above the federal poverty level who, as determined by the site manager, are unable, for good cause, to pay for family planning services. Instances where fees are waived are documented in the client record. **(8.4.3)**
- For clients from families whose income exceeds 250% of poverty, the agency has a schedule of fees designed to recover the reasonable cost of providing services; and the agency has a documented process for determining costs of providing services. **(8.4.4)**
- If the agency has opted to design a fee schedule to recover costs lower than the total cost of providing services, a policy approved by the local governing board is in place and identifies the intended percentage of costs to be recovered. **(8.4.4.A)**
- The agency's written policies on billing and collections include a policy on the "aging" of outstanding accounts. **(8.4.8.A)**

Documentation Required:

- Client records showing eligibility determination for services
- Billing records
- Sliding fee schedule using current MDHHS Poverty Guidelines
- Written agency policy for charging, billing, and collecting client fees
- Agency procedure for aging outstanding accounts

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

Evaluation Questions:

- Are fees waived for individuals with family incomes above the federal poverty level who, as determined by the site director, are unable to pay for services? Are incidents where fees are waived for good cause documented in the client record?

Section X: Family Planning

MPR 9

If a third party (including a government agency) is authorized or legally obligated to pay for services, all reasonable efforts must be made to obtain the third-party payment without application of any discounts. Where the cost of services is to be reimbursed under title XIX, XX, or XXI of the Social Security Act, a written agreement with the title agency is required.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(9)*

Indicator 9.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.4.4
- 8.4.6
- 8.4.7
- 8.4.8

To fully meet this indicator:

- The agency has a schedule of fees/charges that is designed to recover the reasonable costs of providing services. There is a documented process for determining how the schedule of fees is designed to recover reasonable costs of providing services. **(8.4.4)**
- Where there is legal obligation or authorization for third party reimbursement; all reasonable efforts must be made to obtain third party payment, without application of any discounts. **(8.4.6)**
- With regard to insured clients whose family income is at or below 250% federal poverty level; where copayments or additional fees apply, clients are never charged more than they would pay if services were charged on the schedule of discounts. **(8.4.6)**
- Where reimbursement is available from Title XIX or Title XX of the Social Security Act, the agency has written agreements with Title XIX, or XX agencies, for reimbursement from these agencies**. (8.4.7)**
- The agency makes reasonable efforts to collect charges without jeopardizing client confidentiality. **(8.4.8)**

Documentation Required:

- Written agreements with the title agencies for cost reimbursements for services provided to eligible clients, if applicable
- Client records showing third party eligibility for services
- Written policy and/or procedures for charging, billing, and collecting client fees from third party payers
- Billing for Title XIX, XX, or XXI and receipts of reimbursements

Evaluation Questions:

- Does the agency staff follow the billing and client fee collection procedures?

Section X: Family Planning

MPR 10

Provide for an advisory committee.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (a)(11).*

Indicator 10.1

See Michigan Title X Family Planning Standards & Guidelines

- 11.1.A;
- 11.1.A.1,2,3

To fully meet this indicator:

The agency has a governing board or a program specific Family Planning Advisory Council (FPAC) or other appropriate advisory group: **(11.1.A)**

- The council/board is broadly representative of the population served and includes people knowledgeable about family planning. (**11.1.A.1**)
- Responsibilities of the council/board include the following: **(11.1.A.2)**
  - Review the agency's program plan, assess accomplishments and suggest future program goals and objectives.
  - Review the agency's progress toward meeting the needs of the priority population and for making clinic services and policies responsive to the needs of the community.
- There is documentation that the council/board meets at least once a year. **(11.1.A.2)**
- Minutes are kept of all meetings **(11.1A.3)**

Documentation Required:

- Governing Board or FPAC Roster
- Governing Board or FPAC meeting schedule
- Governing Board or FPAC meeting minutes

Evaluation Questions:

None

Section X: Family Planning

Indicator 10.2

Information and Education (I&E) Committee

See Michigan Title X Family Planning Standards & Guidelines
- 12.
- 12.1; 12.2; 12.3; 12.4
- 12.5

To fully meet this indicator:

- The agency has an I & E committee that reviews and approves all informational and educational materials developed or made available by the project prior to their distribution. (The Family Planning Advisory Committee/Advisory Board may take on this role so long as it meets the following requirements.) (**12; 12.1)**
- I & E committee membership is broadly representative of the community served. **(12.2)**
- The size of I & E committee is five to nine members, unless size of body has been waived for good cause by OPA via MDHHS approval and request. **(12.3)**
- The I & E committee must have a written description of the review and approval process in a policy statement, by-laws or other committee documents. **(12.4.A)**
- The I & E committee must consider: **(12.4.C;12.4.D)**
  - The educational and cultural backgrounds of the individuals to who the materials are addressed
  - The standards of the population to be served with respect to such materials
  - Review the content to assure the information is factually accurate
  - Determine whether the material is suitable for the population or community
  - Considerations are documented using an approved MDHHS evaluation form.
- I & E Committee meets at least once a year or more often as needed**. (12.4.F.)**
- Maintains a written record of the determinations and approval process including: **(12.4.G)**
  - Minutes of all meetings, which include a record of determinations regarding the materials reviewed
  - Completed evaluation forms or a compiled summary of forms
  - A master listing of approved materials and dates approved
- Federal grant support is acknowledged in any publication produced with family planning grant funds. **(12.5)**

Documentation Required:

- I & E Committee Roster
- Demonstration of efforts to recruit and prioritize client and community members to the I & E Committee
- I & E Committee Meeting Minutes
- I & E determinations related to materials, including individual evaluation forms or a record of individual evaluation forms, and a Master List of approved materials

Evaluation Questions:

- Does the I & E committee review the content of all informational and educational materials to assure the information is correct?
- Does the I & E committee membership broadly represent the community served? Does not include program staff and prioritizes including client and community members?
- Does the I & E committee roster indicate what portions of the community served individual members represent?

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

- Is there a written record of the determinations of I & E committee for all materials reviewed, including Committee Meeting Minutes, Master list of approved materials with dates approved, Individual Evaluation Forms, or a Record of Individual Evaluation forms used.
- Do publications produced with family planning grant funds acknowledge federal grant support?

Section X: Family Planning

MPR 11

Provide for medical services related to family planning (including physician's consultation, examination prescription, and continuing supervision, laboratory examination, contraceptive supplies) and necessary referral to other medical facilities when medically indicated, and provide for the effective usage of contraceptive devices and practices.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(1)*

Indicator 11.1

All family planning services must be provided using written clinical protocols that are in accordance with nationally recognized standards of care, signed by the medical director responsible for program medical services. **(9.6; 18.A; 29.A.4)**

See Michigan Title X Family Planning Standards & Guidelines

- 9.6; 9.7; 9.8
- 17
- 18.A,B
- 19.B.C.E.F.G.H.I
- 20.A
- 29.A; 29.D; 29.E

To fully meet this indicator:

The agency must:

- Offer medical services related to family planning required in the Title X statute, Title X program requirements, QFP, or MDHHS Standards and Guidelines for the provision of quality family planning services to clients who want such services. **(9.7; 9.8; 17; 18.A & B; 19; 21; 22; 23; 24; 25; 26; 28)**
  - Contraceptive services
  - Pregnancy testing and counseling
  - Achieving desired pregnancy
  - Basic infertility
  - Preconception health
  - Sexually transmitted disease (STD)
  - Related preventive health
  - Referrals for specialist care, as needed
- Clinical protocols must be consistent with the QFP, MDHHS Title X Standards and Guidelines, State of Michigan Laws, and nationally recognized standards of care. **(18.B)**
- Use approved protocols for the provision of all family planning services **(18.A)**
  - Protocol manual must be available at each clinic site. **(18.A)**
  - MDHHS Title X Family Planning Standards and Guidelines Manual must be at each site **(18.B)**
- Clinical protocols and procedures are reviewed and signed annually (within the past 12 months) by the medical director. **(18.B; 29.E.2.e)**
- Obtain a signed general consent for services prior to the client receiving any clinical services **(19.D; 20.A)**

Section X: Family Planning

- Provide an explanation of all procedures, range of available services, and agency fees and financial arrangements to clients **(19.A.7)**
- Have in place protocols that address the following: (**19.B.C.E.F.G.H.I)**
  - Provide that individual education and counseling is offered prior to the client making an informed choice regarding family planning services. **(19.B.C.)**
  - Provide that medical history, physical exam and laboratory test requirements for specific methods of contraception are followed **(19.E.F.G.)**
  - Provide that referrals and follow-up are provided, as indicated, including: **(19.I; 29.A)**
    - Referrals made as result of abnormal physical exam or laboratory findings
    - Paid referrals for required services not provided on site
    - Referrals for services determined to be necessary but beyond the scope of family planning
- Revisits are individualized based on the client's need for education, counseling and clinical care beyond that provided at the visit. **(19.H.2; 19.I.2; 29.D.c.4)**

Documentation Required:

- Service protocol and procedure manuals
- Health care service plan
- Access to client medical records

Evaluation Questions:

- Do clients receive an explanation of all procedures and range of available services?
- Is a written general consent for services (covering exam and treatment) signed by the client prior to receiving any clinical services and maintained in the medical record?

Indicator 11.2

See Michigan Title X Family Planning Standards & Guidelines
Client History and Physical Examination
19. E
21. E.1, 2; 21F.1, 2
22. A.B.C.D
23. A.B.D.E.
25. C.1, 2.a-o
25. C.3.a-e
25. D.1, 2.a-l
25. D.3.a-e
26. A.B.1-5;
26. C.D.1, 2, 6, 7
21. F.1.d, e
28. A. B. C.
29. D.2.g

To fully meet this indicator:

- Medical history and physical examination elements must be appropriate to the type of services provided (female and male clients) as follows: **(19.E.)**
  - Medical history elements required for the female contraceptive client: **(21.E.1)**

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

- Reproductive life plan
- Menstrual history
- Gynecologic history
- Obstetrical history
- Contraceptive use
- Allergies
- Medications
- Immunizations
- Recent intercourse
- Reproductive history
- Present infectious or chronic health conditions
- Zika risk assessment
- Other characteristic and exposures that may impact MEC for contraceptive methods
- Social history/risk behaviors
- Sexual history and risk assessment
- Mental health
- Intimate partner violence
- Interest in sterilization, if age appropriate

- Medical history elements required for the male contraceptive client: **(21.E.2)**
  - Reproductive life plan
  - Use of condoms
  - Allergies
  - Medications
  - Immunizations
  - Recent intercourse
  - Partner history
  - Present infectious or chronic health conditions
  - Zika risk assessment
  - Contraceptive experiences and preferences
  - Sexual history and risk assessment
  - Interest in sterilization, if age appropriate
- Taking of a medical history must not be a barrier to making condoms available in the clinical setting **(21.E)**
- The following physical and laboratory assessment must be provided for female contraceptive clients: **(21.F.1)**
  - Blood pressure evaluation when providing combined hormonal method
  - Bimanual exam and cervical inspection (prior to IUD insertion, diaphragm or cervical cap fitting)
  - Pap screening and clinical breast exam as indicated by current recommendations
  - Chlamydia testing offered annually to females <25 years of age and as indicated by risk factors for women 25 years old or older
  - CT and GC testing must be available for all clients requesting IUD, if indicated.
- No laboratory tests are required for male contraceptive clients, unless indicated by history. **(21.F.2)**
- Referral for Zika screening as indicated
- Medical history elements required for the female preconception health client: **(22.A)**
  - Reproductive Life Plan
  - Sexual risk assessment
  - Reproductive history
  - History of prior pregnancy outcomes
  - Environmental exposures

Section X: Family Planning

- Medications
- Genetic conditions
- Family history
- Intimate partner violence
- Social history/risk behaviors
- Immunization status
- Depression
- Zika risk assessment

- Medical history elements required for the male preconception health client: **(22.B)**
  - Reproductive Life Plan
  - Sexual health assessment
  - Past medical and surgical history that impairs reproductive health
  - Genetic conditions
  - History of reproductive failures/conditions that could reduce sperm quality
  - Social history/risk behaviors
  - Environmental exposures
  - Immunization status
  - Depression
  - Zika risk assessment
- The following physical and laboratory assessment must be provided for all preconception health clients (**22.C,D)**
  - Height, weight, BMI
  - Blood pressure
  - Laboratory testing must be recommended based on risk assessment
- Medical history and client assessment elements for female achieving pregnancy clients (attempting pregnancy less than 12 months) **(23.A, B)**
  - Reproductive Life Plan
  - Length of time attempting pregnancy
  - Partner involvement
  - Zika risk assessment
  - Immunizations
  - Medications
  - Present infections or chronic health conditions
  - Genetic conditions
  - Environmental exposures
  - Social history/risk behaviors
  - Sexual health/risk assessment
  - Mental health
  - Medical history including
    - Reproductive history
    - Obstetrical/Gynecology history
    - Family history
    - Intimate partner violence
- Medical history and client assessment elements for male achieving pregnancy clients (attempting pregnancy less than 12 months) **(23. A,B)**
  - Reproductive Life Plan
  - Length of time attempting pregnancy
  - Partner involvement
  - Zika risk assessment

Section X: Family Planning

- Immunizations
- Medications
- Present infections or chronic health conditions
- Genetic conditions
- Environmental exposures
- Social history/risk behaviors
- Sexual health/risk assessment
- Mental health
- Medical history including
    - Past medical/surgical history that may impair reproductive health
    - Medical conditions associated with reproductive failure/reduced sperm quality

- Medical history elements required for the female basic infertility care client: **(25.C.1,2.a-o)**
    - Reproductive Life Plan
    - Past surgeries
    - Previous hospitalizations
    - Serious illnesses or injuries
    - Medical conditions associated with reproductive failure
    - Childhood disorders
    - Cervical cancer screening results and any follow-up treatment
    - Medications
    - Allergies
    - Social history/risk behaviors
    - Family history of reproductive failures
    - Reproductive history
    - Level of fertility awareness
    - Previous evaluation and treatment results
    - Sexual history
    - Review of systems
    - Zika risk assessment
- Medical history elements required for the male basic infertility care client: **(25.D.1,2.a-i)**
    - Reproductive Life Plan
    - Reproductive history
    - Medical illnesses
    - Prior surgeries
    - Past infections
    - Medications
    - Allergies
    - Lifestyle exposures
    - Sexual health assessment
    - Female partners' history
    - Zika risk assessment
- Physical examination must be offered for female basic infertility clients, if indicated: **(25.C.3.a-e)**
    - Height, weight, and BMI
    - Thyroid examination
    - Clinical Breast Exam
    - Signs of androgen excess
    - Pelvic examination
- Physical examination must be offered for male basic infertility clients, if indicated: **(25.D.3.a-e)**
    - Examination of the penis

Section X: Family Planning

    - Palpation and measurement of the testes
    - Presence and consistency of vas deferens and epididymis
    - Presence of varicocele
    - Secondary sex characteristics
- Medical history elements required for STD services clients include: **(26.A.B.1-5)**
    - Reproductive Life Plan
    - Allergies
    - Medications
    - Medical conditions
    - Sexual health assessment
    - Immunizations (Hep.B, HPV)
    - Zika risk assessment
- Physical and Laboratory assessment required for STD services clients include: **(26.C.D.1,2,6,7; 21.F.1.d,e)**
    - Physical exam as indicated based on history or symptoms
    - Chlamydia testing must be offered annually for all sexually active females <25 years, if indicated
    - Gonorrhea testing must be offered annually to sexually active females <25 with high risks
    - CT and GC testing must be available for clients requesting IUD insertion, if indicated.
    - When provided on site, agencies must follow current CDC Guidelines and follow state and local reporting requirements
- Agencies must offer/provide clinical breast exam (CBE) based on current recommendations and as medically indicated. **(28.A)**
- Pelvic examination must be provided based on current recommendations and as medically indicated. **(28.B)**
- Agencies must stress the importance of mammography based on current recommendations. **(28.C)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records

Evaluation Questions:

- Are medical history, physical examination and laboratory screening elements based on the specific services provided to the client?
- Is Chlamydia testing offered annually to females <25 and as indicated by risk factors for women over 25?
- Are Zika virus risk assessment, education, prevention strategies, and referrals for screening as indicated incorporated into all core family planning services?

Section X: Family Planning

Indicator 11.3

See Michigan Title X Family Planning Standards & Guidelines

Laboratory Testing and Medical Follow-up (9.6; 9.7; 17; 18; 19.G; 21.F.1.c; 24.A; 26; 28; 28.A; 29.A.1,2,3,6; 29.D.2.c; 29.E.2.a,f,g,h)

To fully meet this indicator:

- Written laboratory protocols and operating procedures must be in place that includes: **(9.6; 17; 18; 19.G, I; 21.F.1.c, d; 24.A; 28; 28.A.2.)**
  - Pregnancy testing must be provided on site as indicated
  - Pap testing must be provided on site as indicated
  - Agency must comply with current MDHHS Family Planning Breast and Cervical Cancer Screening Protocol.
  - STI and HIV testing, or referral for testing, as indicated
  - Laboratory tests must be provided if indicated for a specific method of contraception
- Laboratory audits to assure quality and CLIA compliance must be in place. **(29.E.2.g)**
- Infection control policies and procedures reflecting current CDC recommendations and OSHA regulations must be in place. **(29.E.2.f)**
- Equipment maintenance and calibration must be documented. **(29.E.2.h)**
- Procedures must be established for referral and follow-up for abnormal tests that include: **(29.A.1; 29.A.3.a.b.c; 29.D.2.c.1; 29.E.2.a)**
  - A tracking system to document referrals and follow up procedures
  - A method to identify clients needing follow-up
  - A method to track follow-up results on necessary referrals
  - Documentation in the client record of contact and follow-up
  - Documentation of reasons, actions and follow-up where recommendations/protocols were not acted on
  - Referral procedures must be sensitive to client confidentiality and privacy concerns.
- Agency must maintain current referral lists that include health care providers, local health and human service departments, hospitals, voluntary agencies, and health service projects supported by other federal programs. **(29.A.6)**
  - Referral lists must be updated annually **(29.A.6.a**)
- Written protocols for abnormal Pap testing follow-up must be current and consistent with national standards of care. **(28; 28.A.2)**
  - Agencies must participate in the Family Planning/Breast and Cervical Cancer Control Navigation Program (FP/BCCCP) Joint Project for both breast and cervical cancer diagnostic services.
  - Coordination of care must go through the BCCCNP Coordinator unless other referral/payment arrangements are in place
- If STD testing is provided, agencies must have STD treatment protocols and follow-up procedures consistent with current CDC Guidelines **(26.)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Appropriate CLIA certificate
- Laboratory logs
- Equipment maintenance logs
- Referral/Follow-up Logs

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

Evaluation Questions:

None

Indicator 11.4

See Michigan Title X Family Planning Standards & Guidelines

Medical Emergency/Situations and Equipment and Supplies

- 19.J
- 29.A.5
- 29.B.6
- 29. C.1, 2, 4

To fully meet this indicator:

- Emergency arrangements must be available for after hours and weekend care and should be posted. **(19. J)**
- There must be protocols and procedures for the following on-site medical emergency situations: **(29.C.1**)
  - Vaso-vagal reactions/Syncope (fainting)
  - Anaphylaxis
  - Cardiac arrest
  - Shock
  - Hemorrhage
  - Respiratory difficulties
- Protocols must be in place for emergencies requiring EMS transport, after hour's management of contraceptive emergencies, and clinic emergencies **(29.C.2)**
- Procedures for maintenance of emergency resuscitative drugs, supplies, and equipment must be in place **(29.C.4)**
- At a minimum each clinical site must have the following: **(29.B.6)**
  - Emergency drugs and supplies for treatment of vaso-vagal reaction
  - Emergency drugs and supplies for treatment of anaphylactic shock
- When a client is referred for emergency clinical care the agency must: **(29.A.5)**
  - Document that the client was advised of the referral and importance of follow-up
  - Document that the client was advised of their responsibility to comply with the referral

Documentation Required:

- Service protocol and procedure manuals
- Evidence of emergency drug and supply maintenance

Evaluation Questions:

None

Section X: Family Planning

Indicator 11.5

See Michigan Title X Family Planning Standards & Guidelines
Pharmaceuticals/Prescriptions (29.B)

To fully meet this indicator:

- Agencies must operate in accordance with Federal and State laws relating to security and record keeping for drugs and devices. **(29.B)**
- Inventory, supply, and provision of pharmaceuticals must be conducted in accordance with Michigan state pharmacy laws and profession practice regulations. **(29.B)**
- Agencies writing prescriptions for Title X clients must follow the MDHHS prescription policy including: **(21.B.10; 29.B)**
  - Accepting a written prescription does not pose a barrier for the client
  - Prescriptions may only be written for items on the agency formulary or for contraceptives/medications on the client's insurance plan formulary **(21.B.10; 29.B)**
- All medications dispensed in Title X clinics must be pre-packaged. **(29.2.a)**
- All prescriptions dispensed (including samples) must be labeled with the following: **(29.B.2.b)**
  - Name/address of dispensing agency
  - Date of prescription
  - Name of the client
  - Name, strength, quantity of drug dispensed
  - Directions for use, including frequency of use
  - Prescriber name (medical director and prescribing practitioner)
  - Expiration date
  - Record number
- All clients receive verbal and written instructions for each drug dispensed, including instructions on how to use, danger signs, how to obtain emergency care, return schedule, and follow-up. **(19.H.1,2; 29.B.2.c)**
- Delegate agencies must have adequate controls over access to medications and supplies, including. **(29.B.3.d)**
  - Contraceptive and therapeutic pharmaceuticals must be kept in a secure place, either under direct observation or locked.
  - Access to the pharmaceuticals must be limited to health care professionals responsible for distributing these items.
- A system must be in place to monitor expiration dates and ensuring disposal of all expired drugs, including drugs for medical emergencies. **(29.B.3.e; 29.C.4)**
- There must be a system in place for silent notification in case of drug recall. **(29.B.3.f)**
- A current formulary, listing all drugs available for Title X clients, must be maintained and reviewed at least annually that includes: **(29.B.4; 21.b.5)**
  - Methods available on site
  - Methods available on site within two weeks
  - Methods available by paid referral
  - Methods available by unpaid referral
- There must be an adequate supply and variety of drugs and devices to meet client contraceptive needs. **(29.B.5)**
- There must be emergency drugs and supplies for the treatment of vaso-vagal reactions and anaphylactic shock at each site where medical services are provided. **(29.B.6; 29.C.4)**

Section X: Family Planning

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Pharmacy logs
- Inventory logs
- Formulary for Pharmaceuticals

Evaluation Questions:

Does the prescription label for dispensed medications include the prescribing practitioner's name?

Indicator 11.6

See Michigan Title X Family Planning Standards & Guidelines

Medical Records and Quality Assurance System (29.D; 29.E)

To fully meet this indicator:

- A medical record is established for all clients who receive clinical services, including pregnancy testing, counseling, and emergency contraception. **(29.D.1.a)**
- Medical records are: **(29.D.1.b)**
  - Complete, legible and accurate
  - Signed and dated by the clinical health professional making the entry, including name, date, and title, as a permanent part of the record
  - Readily accessible
  - Confidential
  - Safeguarded against loss or use by unauthorized persons
  - Available to clients, upon request
- HIPAA regulations are followed. **(29.D.1.c)**
- Medical records contain the following: **(29.D.2)**
  - Personal data sufficient to identify the client:
    - name
    - unique client number
    - address
    - phone, how to contact
    - age
    - sex
    - marital status (Michigan requirement)
    - race & ethnicity (FPAR requirement)
    - Income assessment
  - Medical history, as indicated by service(s) provided
  - Physical exam, as indicated by services(s) provided
  - Allergies
  - Documentation of clinical findings, diagnostic/therapeutic orders, including:
    - Lab test results and follow-up
    - Treatments initiated and special instructions

Section X: Family Planning

  - Continuing care, referral and follow-up
  - Scheduled revisits
- Documentation of all medical encounters, including telephone encounters
- Documentation of all counseling, education, and social services
- Signed general consent for services
- Contraceptive method chosen by the client

- A quality assurance system must be in place to provide ongoing evaluation of family planning services that includes: **(29.E;)**
  - Tracking system that identifies clients in need of follow up and/or continuing care. **(29.E.2.a)**
  - Medical Audits to determine conformity with agency protocols and must be conducted quarterly by the medical director
    - At least 2-3 charts per clinician must be reviewed by the medical director quarterly. **(29.E.2.c)**
  - Chart Audits/Record Monitoring to determine completeness and accuracy of the medical record must be conducted quarterly by the quality assurance committee or identified personnel
    - At least 3% of quarterly caseload, randomly selected are reviewed quarterly **(29.E.2.d)**
  - A process to implement corrective actions when deficiencies are noted must be in place. **(29.E.2.i)**

Documentation Required:

- Service protocol and procedure manuals
- Access to client medical records
- Documentation of Quality Assurance Medical Audits
- Documentation of Chart Audits and/or Record Monitoring

Evaluation Questions:

- Do medical records contain documentation of all medical encounters: medical history and physical exam appropriate to the service(s) provided; documentation of all clinical findings including laboratory test results and follow-up; treatments initiated and special instructions; referrals and follow-up; and scheduled revisits?
- Are medical audits regularly performed by the medical director to assure conformity with agency protocols on a quarterly basis?
- Are Chart Audits/ Record Monitoring Audits to determine completeness and accuracy of medical records being conducted quarterly by a QA committee member or identified personnel?

Section X: Family Planning

MPR 12

Provide for social services related to family planning, including counseling, referral to and from other social and medical services agencies, and any ancillary services which may be necessary to facilitate clinic attendance.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(2)*

Indicator 12.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.5.2
- 9.4; 9.7; 9.11
- 17
- 19.C,I
- 21.G
- 24.A.6; 24.E
- 26.D.6; 26.E.1
- 29.A; 29.A.6; 29.2.f

To fully meet this indicator:

- Counseling services must be provided either on-site or by referral **(9.4; 9.7; 9.11; 17; 19.C,I; 29.A)**
- Referral lists for social services agencies and medical referral resources must be current and reviewed annually. **(24.A.6; 24.E; 29.A.6)**
- The agency must offer education on HIV and AIDS, risk reduction information and either on-site testing or referral for this service. **(17; 26.E)**
- Counseling must be provided by staff that is sensitive to and able to deal with the cultural and other characteristics of the client population. **(8.5.2)**
- Counseling must be accurate, balanced, and non-judgmental on the contraceptive methods, STIs and HIV. **(9.11; 21.G; 26.D.6; 26.E.1)**
- The client counseling must be documented in the client's record. **(21.G; 29.2.f)**

Documentation Required:

- Client medical records with counseling documentation
- Current referral list
- Written formal referral arrangements
- Agency protocols on providing counseling services

Evaluation Questions:

- Are counseling services provided based on the individual client needs/request for services?

Section X: Family Planning

MPR 13

Provide for informational and educational programs designed to: achieve community understanding of the objectives of the program; inform the community of the availability of services; and promote continued participation in the project by persons to whom family planning services may be beneficial.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(3)*

Indicator 13.1

See Michigan Title X Family Planning Standards & Guidelines

- 4
- 5
- Section I Annual Plan Instructions, pp.50,51
- 11.2; 11.3

To fully meet this indicator:

- The agency must submit an Annual Health Care Plan that includes written plans for: **(4; 5; 8.7.A; Section I, Annual Plan Instructions,III.E.F,p.51; 11.2)**
  - Community education activities
  - Community project promotion activities
- The agency must include low-income women and adolescents in the target groups identified for program promotion activities. **(4; 8.7.A; Annual Plan Instructions, II.C.,p.50)**
- The agency's plan for community education programs must include goals, objectives, and measurement criteria and should be based on an assessment of the needs of the service delivery area. **(8.7.A; Annual Plan Instructions, III.E.F,p.51)**
- The agency must establish and implement planned activities to provide community education programs to facilitate awareness and access to family planning services **(11.2: 11.3)**

Documentation Required:

- Annual Health Care Plan
- Documentation of community education activities (such as, flyers, community meeting agendas, brochures, reports, logs)
- Documentation of activities program promotion activities (such as Outreach logs, news releases, articles, PSA's, and advertisements)
- Newsletters and other communications/educational tools as available

Evaluation Questions:

None

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

MPR 14

Provide for orientation and in-service training for all project personnel.

Reference: *42 CFR CH.1 (10-1-00 Edition) §59.5 (b)(4)*

Indicator 14.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.5.1
- 8.5.3
- 8.5.4
- 8.6.1-7
- 13.2
- 29.C
- 29.E

To fully meet this indicator:

- The agency must meet applicable standards established by the federal, state, and local governments (e.g. local fire, building, and licensing codes – non medical emergencies). **(13.2)**
- The agency must have written plans, protocols/operating procedures for non-medical emergency situations, such as fire, tornado, bomb, terrorism, etc. **(13.2, 29. C)**
- The agency must have written personnel policies that comply with federal and state requirement and Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, and Title I of Americans with Disabilities Act (Public Law 101-336). These policies should include: **(8.5.1)**
  - Staff recruitment and selection
  - Performance evaluation
  - Staff promotion
  - Staff termination
  - Compensation and benefits
  - Grievance procedures
  - Patient confidentiality
  - Duties, responsibilities, and qualifications of each position
  - Licenses for positions requiring licensure
- The agency must have a qualified Family Planning project coordinator. **(8.5.3)**
- All clinicians, including mid-level practitioners, must maintain current licensure and certification. **(8.5.4; 29.E.2.b)**
- Personnel records are kept confidential. **(8.5.1.A)**
- Organizational chart and personnel policies are available to all personnel. **(8.5.1.C)**
- Job descriptions are available for all positions and updated as needed. **(8.5.1 D)**
- Performance evaluations of program staff are conducted according to the agency personnel policy. **(8.5.1.B)**
- The agency provides staff training on encouraging family involvement in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities at least every two years. **(8.6.3)**

Section X: Family Planning

- The agency provides for orientation and in-service training for all program personnel, including staff of sub-recipient agencies and service sites. **(8.6.1)**
- The agency provides staff training regarding prevention, transmission and infection control in the health care setting of sexually transmitted infections including HIV as required by OSHA regulations. **(8.6.4)**
- The agency provides staff training in emergency procedures or natural disaster and staff understands their role. **(8.6.5, 13.2.3, 29.C3)**
- The agency provides training regarding the nature and safety of pharmaceuticals to clinical staff involved in dispensing medications at least every two years. **(8.6.7; 29.B.2.d; 29.B.3.a)**
- The agency provides staff training in the unique social practices, customs, and beliefs of the under-served populations of their service area at least every two years. **(8.6.6)**
- The agency must train staff in mandatory reporting and human trafficking laws at least every two years. **(8.6.2)**
- Licensed medical staff providing direct patient care is trained in CPR and have current certification. **(29.C.3; 29.E.2.b)**

Documentation Required:

- Policies and/or procedures for non-medical emergencies, including fire, natural disaster, robbery, power failure, and harassment.
- Agency personnel policies.
- Position descriptions.
- Copies of licenses for those positions requiring licensure.
- Documentation of staff orientation and in-service training, including:
  - Staff training on the unique social practices, customs, and beliefs of the under-served populations in their service area
  - Evidence of staff trained in the prevention, transmission and infection control in the healthcare setting of sexually transmitted infections including HIV
  - Pharmaceutical training for clinical staff involved in dispensing medications
  - CPR training and certification for all licensed medial staff providing direct care
  - Staff training in emergency procedures and plans
  - Staff training on blood born pathogen transmission/OSHA training
  - Staff training on encouraging family involvement in the decision of minors to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities
- Documentation of staff continuing education
- Documentation of performance evaluations as required by agency personnel policy

Evaluation Questions:

- Does the agency keep written documentation of staff meetings?
- Does the agency keep training records on each employee?
- Does the agency have established orientation/in-service training for all staff, including family planning program requirements, philosophy, policies and goals of operation?

Section X: Family Planning

MPR 15

Provide services without the imposition of any durational residency requirement or requirement that the patient be referred by a physician.

Reference: *2 CFR CH. I (10-1-00 Edition) §59.5 (b)(5)*

Indicator 15.1

See Michigan Title X Family Planning Standards & Guidelines

- 9.9

To fully meet this indicator:

- There is a written policy that services are provided without residency requirements or physician referral. **(9.9)**

Documentation Required:

- Non-discrimination policy for residency and physician referral

Evaluation Questions:

None

Section X: Family Planning

MPR 16

Provide that the family planning medical services will be performed under the direction of a physician with special training or experience in family planning.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(6)*

Indicator 16.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.5.4
- 9.6
- 18.A,B
- 29.B.1,2
- 29.E.2.c,e

To fully meet this indicator:

- The medical director must be a licensed, qualified physician, with special training or experience in family planning. **(8.5.4)**
- The medical director approves and signs protocols and standing orders annually (within the past 12 months). **(9.6; 18.A,B; 29.E.2.e)**
- Clinicians other than physicians performing medical functions do so under protocols and/or standing orders approved by the medical director. **(8.5.4.A,B)**
- The medical director directs medical services and participates in quality assurance activities. **(29.E.2.c)**
- Prescription of pharmaceuticals must be done under the direction of a physician who must have a drug control license for each clinic location in which storage and dispensing occurs. **(29.B.1.a; 29.B.2)**

Documentation Required:

- Evidence that all mid-level providers have agreed to follow clinic procedures, protocols, and standing orders are signed and approved by the medical director
- Medical director's professional and drug control licenses for each clinic location
- Approved protocols and standing orders
- Curricula vitae of medical director

Evaluation Questions:

None

Section X: Family Planning

MPR 17

Provide that all services purchased for project participants will be authorized by the project director or his/her designee on the project staff.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(7)*

Indicator 17.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.3.2; 8.3.3; 8.3.4; 8.3.6
- 8.5.4
- 9.6
- 8.7
- Section I, Annual Plan Instructions, pp.50,51
- 13,5
- 18.A
- 21.B.6
- 29.A.4
- 29. B.3.b, c, d.
- 10.2 A. 3

To fully meet this indicator:

- All services must be provided according to approved protocols. **(8.5.4; 9.6; 18.A)**
- Required services provided by referral must have formal arrangements with the referral provider that includes a description of the services provided and includes cost reimbursement information. **(8.3.4; 29.A.4; 21.B.6)**
- The current annual plan identifies all services to be provided. **(8.7; Section I, Annual Plan Instructions, III.H p.50)**
- Safeguards must be in place to assure that drugs purchased through the 340B program are only used for family planning clients. **(29.B.3.d.3)**
- The agency must have proper segregation between requisition, procuring, receiving, and payment functions for pharmaceuticals and supplies. (**29.B.3.b,c)**
- There must be an inventory system to control purchase, use, and reordering of pharmaceuticals and supplies. **(29.B.3.c)**
- If a delegate agency subcontracts for services, a formal agreement consistent with Title X requirements must be current and have appropriate approval. **(8.3.2)**
- Documentation and records of all expenditures must be maintained. **(8.3.6; 13.5)**
- All services purchased for project participants must be authorized by the project director or his/her designee on the project staff (**8.3.3)**

Documentation Required:

- Clinical protocols
- Operating policies and procedures
- Required services provider agreements

For technical assistance, contact Barbara Derman at 517-335-8696 or dermanb@michigan.gov

Section X: Family Planning

- Annual Plan
- Subcontract agreements
- Records of pharmaceutical requisitions
- Documentation of Inventory system
- Records of equipment purchases over the past three years

Evaluation Questions:

None

Section X: Family Planning

MPR 18

Provide for coordination and use of referral arrangements with other providers of health care services, local health and welfare departments, hospitals, voluntary agencies, and health services projects support by other federal programs.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(8)*

Indicator 18.1

See Michigan Title X Family Planning Standards & Guidelines

- 9.7
- 17
- 29.A.1,2,3,4,5,6

To fully meet this indicator:

- Projects must provide necessary referrals to other medical facilities as medically indicated. **(9.7; 17)**
- The agency must have referral arrangements in place for the following: **(29.A)**
  - Referrals made as a result of abnormal physical exam or laboratory findings
  - Referrals for required services not provided on-site
  - Referrals for services determined necessary but beyond the scope of Family Planning
- Referral and follow up procedures must be sensitive to the client's concerns for confidentiality and privacy. **(29.A.1)**
- Client consent for release of information to providers must be obtained, except as may be necessary to provide care or as required by law. **(29.A.2)**
- The agency must have written protocols/procedures for follow-up on referrals that are made as a result of abnormal physical examination or laboratory test findings. These protocols must include a system to document referrals and follow up procedures, including: **(29.A.3)**
  - A method to identify clients needing follow up
  - A method to track follow up results on referrals
  - Documentation in the client record of contact and follow up
  - Documentation of reasons, actions where recommendations were not followed
- When required services are provided by referral, the agency must have in place formal arrangements with a referral provider that includes a description of the services provided and costs. **(29.A.4)**
- For services determined to be necessary but beyond the scope of Family Planning, clients must be referred to other providers for care, the agency must: **(29.A.5)**
  - Document that the client was advised of the referral and the importance of follow up
  - Document that the client was advised of their responsibility to comply with the referral
  - Maintain appropriate safeguards for confidentiality
- Referral lists for social services agencies and medical referral resources must be current and updated annually. **(29.A.6.)**

Section X: Family Planning

Documentation Required:

- Protocol/procedure for selecting and referring to other health care, local health and welfare departments, hospitals, voluntary agencies or health services projects
- Referral agreements between the agency and organizations providing required services
- Current list of referral agencies
- Documentation of referrals and follow-up

Evaluation Questions:

None

Section X: Family Planning

MPR 19

Provide that if family planning services are provided by contract or other similar arrangements with actual providers of services, services will be provided in accordance with a plan which establishes rates and method of payment for medical care. These payments must be made under agreements with a schedule of rates and payments procedures maintained by the agency. The agency must be prepared to substantiate that these rates are reasonable and necessary.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(9)*

Indicator 19.1

See Michigan Title X Family Planning Standards & Guidelines

- 8.3.2
- 8.3.4

To fully meet this indicator:

- The agency must have in place formal arrangements regarding provision of services and reimbursement of costs for contractual services. **(8.3.2; 8.3.4)**

Documentation Required:

- Copies of contractual agreements for family planning services purchased.

Evaluation Questions:

- Are formal agreements in place with contractual providers such as physicians, nurse practitioners, medical directors, or other staff who are not agency employees?
- Do agreements with contractual providers include payment arrangements?

Section X: Family Planning

MPR 20

Provide, to the maximum feasible extent, an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served, and by others in the community knowledgeable about the community's needs for family planning services.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.5 (b)(10)*

Indicator 20.1

See Michigan Title X Family Planning Standards & Guidelines

- 11.1; 11.2

To fully meet this indicator:

- The agency must provide an opportunity for participation in the development, implementation, and evaluation of the project. **(11.1)**
- The agency plan must include plans for community participation. **(11.2)**

Documentation Required:

- Community participation plan section of the Annual Plan.
- Documentation that plan has been accomplished, as appropriate.

Evaluation Questions:

None

Section X: Family Planning

MPR 21

Any funds granted shall be expended solely for the purpose of delivering Title X Family Planning Services in accordance with an approved Plan & budget, regulations, terms & conditions and applicable cost principles prescribed in 2 CFR Chapter I, Chapter II, Part 200, as applicable.

Reference: *42 CFR CH. I (10-1-00 Edition) §59.9*

Indicator 21.1

See Michigan Title X Family Planning Standards & Guidelines

- 7
- 8.3.6
- 13.5.A
- Audit requirements are found in Section I Financial Management Audit Requirements, pp. 57,58)

To fully meet this indicator:

- The agency must have a separate budget for Title X funds. **(7)**
- The agency budget must be developed and approved annually by MDHHS. **(7)**
- The agency must have an annual financial audit conducted in accordance with provisions of 2 CFR Part 200. (Section I, Financial Management Audit Requirements, pp.57,58)
- The agency must have an annual financial audit conducted in accordance with provisions of 2 CFR Part 200. (Section I, Financial Management Audit Requirements, pp.57,58)
- The agency's must have a system in place for collecting all required data elements for the FPAR, including accurate, complete, and current financial data for Table 14. **(13.5.A)**

Documentation Required:

- Budget/CPBC
- Financial Status Report
- Ledger
- Financial audit
- Contracts
- Family Planning Annual Report
- Completed Pre-visit Fiscal Review Questionnaire

Evaluation Questions:

- Does the agency have written financial audits?
- Have financial audit findings been addressed?
- Are all sources of funds identified in the operating budget?

Section XI: Women, Infants, and Children Administration (WIC)

MPR 1

The WIC Management Evaluation and Corrective Plan of Action (as required) are conducted and satisfactorily completed on a biennial basis as mandated by the United States Department of Agriculture.
(7 CFR 246.9(a), WIC Policy 1.05)

Indicator 1.1

The previous WIC Management Evaluation Review (12 Months prior to the Accreditation Date) and its follow-up Corrective Plan of Action (CPA) is successfully completed, near completion or progressing toward completion; or there were no citations found during the Management Evaluation Review. (7 CFR 246.9 (a), WIC Policy 1.05)

This indicator may be met by:

The WIC Management Evaluation (ME) must have all Met Indicators, or the WIC ME CPA for each of the indicators must be Met/Completed.

See WIC 2015 Schedule for applicable WIC ME, WIC Follow-Up CPA.

Documentation Required:

ME status letter indicates all indicators MET.

Final ME Follow up Review Corrective Plan of Action letter shows all indicators MET or complete.

Evaluation Questions:

- Are all WIC ME indicators Met?
- Are all WIC ME CPA indicators met or completed?

To access the 2017 Management Evaluation Review Tools, please use this web address:
http://www.michigan.gov/mdch/0,1607,7-132-2942_4910_19205_21312-256470--,00.html

For technical assistance, please contact Nancy Erickson at 517-335-9562 or ericksonn@michigan.gov, or Kristen Hanulcik at 517-335-8545 or hanulcikk@michigan.gov

Section XII: Children's Special Health Care Services (CSHCS)

MPR 1

The local health department (LHD) Children's Special Health Care Services (CSHCS) program shall assure that adequate, trained personnel are available to provide outreach, enrollment, and support services for children and youth with special health care needs (CYSHCN) and their families.

Reference: *CSHCS Guidance Manual for Local Health Departments, Standard of Practice.*

Indicator 1.1

LHD CSHCS shall maintain a staffing configuration that includes a Registered Nurse and a program representative to provide program services to CSHCS client caseload and meet program requirements. When changes occur, the LHD shall submit a CSHCS staff roster to the Michigan Department of Health & Human Services (MDHHS) CSHCS program and shall notify the MDHHS when changes to the roster occur.

This indicator may be met by:

There shall be evidence that the staffing is adequate to provide the required program services to the community and caseload. The table below provides recommended staffing levels based on caseload. It is incumbent on each LHD to determine the appropriate staffing levels/configuration to meet the needs of the community and of the CSHCS enrolled caseload.

Caseload Ranges	Recommended Registered Nurse FTE	Recommended Program Representative FTE
<150	.25	.25
150-400	.50	.25-.50
401-600	1.0	.50
601-800	1.0-1.5	1.0
801-1,300	2.0	1.0-1.5
1,301-2,000	2.0-2.5	1.5-2.0
2,001-2,800	3.0	2.0
2,801-3,300	5.0	5.0
>3,300	6.0	6.0

There shall be evidence of a current, accurate staff roster. If changes have been made to the staffing, documentation exists showing that the revised roster was sent to MDHHS.

Documentation Required:

All below are required.

- Full staff roster from the entire three year review period indicating the LHD CSHCS staffing configuration, including position, county assignment (if applicable), CSHCS start date, CSHCS end date (if applicable), and FTE amounts for all staff working within CSHCS. The roster should match the reported and observable staffing. *Materials should be submitted in advance of the review.*
- On-site interview describing how the LHD CSHCS staffing configuration adequately meets the needs of the community (outreach/case-finding) and of the CSHCS enrolled caseload.

Section XII: Children's Special Health Care Services (CSHCS)

If changes to the staffing roster occur, the following are also required:

- Dated correspondence (electronic or written) that the staff roster was submitted to MDHHS CSHCS program following changes to staffing. *Materials should be submitted in advance of the review.*
- Personnel records indicating when staffing changes occurred as compared to submission of roster to MDHHS CSHCS program.

Evaluation Questions:

- Does the LHD staffing configuration allow the LHD to provide quality, CSHCS-required services?
- Is the LHD CSHCS Program maintaining an accurate CSHCS staff roster and communicating changes in staffing to MDHHS?

Indicator 1.2

New LHD CSHCS employees shall take required courses, as listed on the CSHCS website, within 90 days of employment. All LHD CSHCS staff shall take these courses within 90 days of notification that the training courses have been updated. At least one person from each health department's CSHCS program shall participate in CSHCS state-office regional meetings.

This indicator may be met by:

There shall be evidence that exists of timely staff training using required courses within the specified timeframes.

There shall be evidence of routine staff training/updating through participation in the CSHCS sponsored regional LHD meetings by at least one person from each health department.

Documentation Required:

All below are required.

- Written policy and procedure delineating staff training of new and on-going employees.
- Printed certificate of completed required training courses including name and date. *Materials should be submitted in advance of the review.*
- Dated notation in the employee's personnel record by the supervisor that the other required courses have been taken when no printable certificate available for the training exists. *Materials should be submitted in advance of the review.*
- Staff roster with county assignment as compared to the CSHCS regional meeting sign-in sheet showing registrants and attendees (signature of attendees). If attendee neglected to sign in, other evidence of attendance as possessed by attendee/LHD.

Evaluation Questions:

- Are LHD CSHCS program staff oriented timely and then updated as needed to the CSHCS program through use of required courses, as listed on the CSHCS website?
- Did at least one CSHCS staff person from each health department attend MDHHS sponsored CSHCS regional meetings?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 2

In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.

Reference: *HIPAA, CSHCS Guidance Manual for Local Health Departments, Standard of Practice.*

Indicator 2.1

The LHD CSHCS program staff shall routinely use the CSHCS database to securely manage CSHCS client PHI and effectively and efficiently coordinate care.

This indicator may be met by:

There shall be evidence of proficient and regular use of the CSHCS database by LHD CSHCS program staff to successfully carry out local CSHCS functions.

Documentation Required:

All below are required.

- Written policy and procedure delineating use of the CSHCS database to carry out daily functions.
- During On-site Reviews, LHD staff will be asked to demonstrate proficiency with the database by showing Reviewers how to find one or more of the following pieces of information using the CSHCS database:
    - Client look-up
    - Medical report received date
    - Medical report approved date
    - Listing of approved providers
    - Renewal information
    - Where to find MDHHS/CSHCS notes
    - Client eligibility begin/end dates
    - Client in TEP status
    - How to print county-specific reports

Evaluation Questions:

- Are the LHD staff using the CSHCS database regularly and accurately to efficiently, effectively, and securely obtain the information necessary to carry-out their daily functions such as communicating with CSHCS-enrolled clients and/or their families and coordinating CSHCS client care?
- Are policy and procedures in place that include use of the CSHCS database?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 2.2

The LHD CSHCS program staff shall use the secure electronic method of communication for sharing of PHI designated by CSHCS (e.g. DMP).

This indicator may be met by:

There shall be evidence of proficient and regular use of the designated electronic system for sharing PHI, by the appropriate LHD CSHCS program staff to successfully carry out CSHCS functions.

Documentation Required:

All below are required.

- Written policy and procedure delineating use of the designated electronic data system for secure sharing of CSHCS PHI to carry out daily functions.
- Evidence of use of this data system (system "footprints" of use).

Evaluation Questions:

- Are the LHD staff regularly and accurately using the designated electronic system for sharing PHI to efficiently, effectively, and securely share the information necessary to carry-out their daily functions including communicating with MDHHS and coordinating CSHCS client care?
- Are policy and procedures in place that includes use of the designated electronic data system for sharing PHI?

Indicator 2.3

LHD CSHCS shall have a shared, comprehensive client record for CSHCS enrollees that reflects communication among the staff and includes dates and staff identifier.

This indicator may be met by:

There shall be evidence that the LHD maintains comprehensive client record on all CSHCS enrollees that all local CSHCS staff use to record contacts and document services provided.

Documentation Required:

All below are required.

- Physical evidence of comprehensive client records exists. The previous three years' activities in client charts should be submitted in advance of the review (individual clients will be specified by MDHHS).
- Evidence that all CSHCS staff record contacts/CSHCS services in one client record including date of interaction and staff identifier.
- Evidence of referrals within the program (CSHCS program representative referring to CSHCS nurse and vice versa).

Section XII: Children's Special Health Care Services (CSHCS)

Evaluation Questions:

- Does the LHD CSHCS program maintain shared client records (all staff document in one, comprehensive client record)?
- Do the chart notations indicate communication among the CSHCS staff to ensure coordination of care for the CSHCS client?
- Do all client record notations include a date and staff identifier?

Indicator 2.4

LHD CSHCS shall only access the minimum information necessary in the CSHCS database or other electronic data systems to complete tasks for CSHCS clients.

This indicator may be met by:

There shall be evidence that LHD CSHCS staff implement the privacy provisions of HIPAA in carrying out their CSHCS tasks using the CSHCS electronic data systems and that staff receive the local health department's policy and procedure regarding HIPAA compliance.

Documentation Required:

All below are required.

- Evidence that HIPAA compliant LHD policy and procedures have been shared with LHD CSHCS staff.
- Written policy and procedure delineating HIPAA compliant use of the CSHCS database.
- The LHD maintains on file a copy of signed and dated HIPAA Agreement to Comply for each employee. *Materials should be submitted in advance of the review.*
- On-site interview of how LHD CSHCS staff uses the data systems in a HIPAA compliant manner.

Evaluation Questions:

- Have the LHD CSHCS staff received the LHD policy and procedure regarding HIPAA compliance?
- Have the LHD CSHCS staff been informed of HIPAA rules regarding privacy and have they signed an agreement to comply with these rules?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 2.5

LHD CSHCS shall offer families a private location for the exchange of confidential information.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program has a private location and it is offered to CSHCS families where they can privately exchange confidential information.

Documentation Required:

All below are required.

- Written policy and procedure delineating how families are offered a private location to share confidential information with the LHD CSHCS staff.
- Physical evidence of a private location.
- On-site interview of how/when LHD CSHCS staff offer CSHCS clients and/or families the opportunity to discuss confidential information in a private location.

Evaluation Question:

- Does the LHD CSHCS program have a private location for discussion of confidential information with CSHCS clients and/or families and is it routinely offered to them?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 3

The local health department CSHCS program shall have family-centered policies and procedures in place, as well as accurate and timely reporting.

Reference: *(CSHCS Guidance Manual for Local Health Departments, Michigan Department of Community Health Medicaid Provider Manual, Standard of Practice, Health Resources and Services Administration (HRSA)/Maternal and Child Health Bureau (MCHB), Sec. 501 of Title V of the Social Security Act, MCHB Performance Indicator).*

Indicator 3.1

LHD CSHCS shall regularly use the most current Children's Special Health Care Services Guidance Manual for Local Health Departments (Guidance Manual) and the Medicaid Provider Manual to effectively and consistently carry out local program expectations, policies, and requirements.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program staff routinely use the CSHCS Guidance Manual and Medicaid Provider Manual in carrying out local program expectations, policies, and requirements.

Documentation Required:

All below are required.

- Written policy and procedure delineating how the LHD uses the most current Guidance Manual and Medicaid Provider Manual.
- On-site interview will include having LHD CSHCS staff demonstrate their proficiency with the Guidance Manual and Medicaid Provider Manual by showing the Reviewer(s) how to find one or more pieces of information in the Guidance Manual and Medicaid Provider Manual as indicated by the Reviewer(s).

Evaluation Question:

- Has the local health department demonstrated compliance and competence in routinely using the current CSHCS Guidance Manual and Medicaid Provider Manual?

Indicator 3.2

LHD CSHCS shall have written policies and procedures in accordance with CSHCS published policy that are reviewed annually and updated as needed regarding local CSHCS program functions.

This indicator may be met by:

There shall be evidence of written policies and procedures (electronic or hard-copy) that stipulate local procedures in accordance with current CSHCS published policy.

There shall be evidence that the written policies and procedures are reviewed annually and updated as necessary. See Addendum 1 for the minimum list of policy statements to submit with procedures.

Section XII: Children's Special Health Care Services (CSHCS)

Documentation Required:

All below are required.

- Written policies and procedures with dated notation of annual review and revisions as necessary. *Materials should be submitted in advance of the review.*

Evaluation Question:

- Does the local health department have written policies and procedures of local functions that are reviewed annually and updated as necessary?

Indicator 3.3

LHD CSHCS shall facilitate family input regarding the local CSHCS program at least annually.

This indicator may be met by:

There shall be evidence of outreach for family involvement for input regarding possible improvements to the overall local CSHCS program.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how and when family input is obtained.

Examples of further documentation to meet the requirement, including but not limited to:

- Copies of outreach to families e.g., family survey documents and results, satisfaction surveys, focus groups, meeting notes etc. *Materials should be submitted in advance of the review.*
- On-site interview that indicates how family input is obtained and the outcome of family input.

Evaluation Questions:

- Has the local health department elicited input from local families regarding the operation of the CSHCS program at the local level and how it could be improved?
- How was the input utilized and/or incorporated to enhance the program?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 4

The local health department CSHCS program shall collaborate with community partners and provide outreach, case-finding, program representation, and referral services to CYSHCN/families in a family-centered manner.

Reference: *MCHB Performance Measures, Michigan Public Health Code, 333.5805 (1) a.*

Indicator 4.1

LHD CSHCS shall routinely conduct outreach, case-finding, and program representation which includes, but is not limited to, the provision of information regarding CSHCS policy on diagnostic referrals, program eligibility, and covered services to families, local hospitals, providers, the community and other agencies.

This indicator may be met by:

There shall be evidence of outreach, case-finding, and program representation to families and community organizations.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how outreach to families and the community is conducted.
- Written policy and procedure delineating how outreach materials are disseminated to families and the community.

Example of further documentation to meet the requirement, including but not limited to:

- Agendas for meetings held with hospitals or other community agencies. *Materials should be submitted in advance of the review.*
- Sign-in sheets including title of meeting, location, and date. *Materials should be submitted in advance of the review.*
- Copies of letter inviting/confirming attendance at community functions or meetings. *Materials should be submitted in advance of the review.*
- Log sheet summarizing outreach efforts. *Materials should be submitted in advance of the review.*
- On-site interview that indicates how outreach, case-finding and program representation to families and community organizations are accomplished. *Materials should be submitted in advance of the review.*

Evaluation Question:

- Does the LHD CSHCS program provide the required outreach, case-finding, and program representation to families and organizations/providers in the community?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 4.2

LHD CSHCS shall partner with and refer CYSHCN and CSHCS clients to other needed services/programs and/or assist in making applications for other programs in the community for which the child and/or family may be eligible.

This indicator may be met by:

There shall be evidence of referral procedures and practices for families of CYSHCN and those enrolled in the CSHCS program. The LHD CSHCS shall have evidence of partnering with and assisting families in applying for other programs for which they might be eligible such as Early On, WIC, MIChild, Healthy Kids, Medicaid, SSI, and Medicare.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating a referral process including information about available community resources for LHD clients with special health needs but not enrolled in CSHCS.
- Written policy and procedure delineating how assistance is provided to families in applying for other programs.

Example of further documentation to meet the requirement, including but not limited to:

- Dated client chart notation in the comprehensive client chart and/or on the plan of care for clients enrolled in CSHCS including staff identifier.
- On-site interview that indicates when and how families of CYSHCN as well as of CSHCS are referred to other needed services/programs.
- Dated client chart notation documenting application assistance and staff identifier.
- Information regarding other program application assistance in the client's Family Needs Summary Checklist.
- Information regarding other program application assistance in the individual plan of care.
- On-site interview that indicates how the LHD assists families in applying for other programs that the client/family may be eligible.

Evaluation Question:

- Does the LHD CSHCS program refer CSHCS clients, as well as clients with special health needs who are not enrolled in CSHCS, to other needed programs and services, and assist families in applying for other programs as applicable?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 4.3

LHD CSHCS shall inform all families about the Family Center for Children and Youth with Special Health Care Needs (Family Center). Written documents sent to families from the LHD shall contain the Family Phone Line toll-free number and the CSHCS website (www.michigan.gov/cshcs).

This indicator may be met by:

There shall be evidence of informing clients/families about the Family Center, to include the Family Phone Line when appropriate, as well as inclusion of the required information on family-focused materials and correspondence to families.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how/when families are informed and/or referred to the Family Center, which includes referral to the Family Phone Line as appropriate.
- Family correspondence and public relations materials contain the Family Phone Line number and the CSHCS website. *Materials should be submitted in advance of the review.*

Example of further documentation to meet the requirement, including but not limited to:

- Dated client chart notation including staff identifier
- Plan of care
- Checklist
- Annual update
- Family correspondence
- Welcome packet
- Information included on the LHD CSHCS website
- On-site interview that indicates when and how families receive information and referral to the Family Center

Evaluation Questions:

- Does the LHD CSHCS program inform all families about the Family Phone Line and Family Center as appropriate?
- Has the LHD CSHCS program included the Family Phone Line toll-free number and the CSHCS website on written correspondence and documents developed for families?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 5

The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

Reference: *Michigan Public Health Code 333.5805, 333.5817, CSHCS Guidance Manual for Local Health Departments.*

Indicator 5.1

LHD CSHCS shall assist any family who is referred to or who contacts the local health department with needs regarding completion of CSHCS application processes and/or forms.

This indicator may be met by:

There shall be evidence that the LHD CSHCS has assisted families who have been referred or who have contacted the LHD for help with the CSHCS application process and/or forms.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure which includes assisting families who are referred or who contact the LHD directly in the completion of the CSHCS application process and/or forms.

Example of further documentation to meet the requirement, including but not limited to:

- Dated client chart notation documenting assistance provided to the client/family in completing the application and/or forms and staff identifier.
- Check box on the application indicating LHD assisted with the CSHCS application.
- On-site interview that indicates how the LHD works with families who are referred or who contact the LHD for help with the CSHCS application process and/or forms.

Evaluation Question:

- Does the LHD CSHCS program assist clients/families who are referred or who contact the LHD with the CSHCS application process and/or other form completion as needed?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 5.2

LHD CSHCS shall locate individuals or families who do not return a CSHCS Application within 30 days after being invited to join CSHCS, to offer assistance with application completion.

This indicator may be met by:

The LHD CSHCS program shall have evidence of attempting to locate those who have not returned an application within 30 days of being invited to join CSHCS and of offering to assist with completing the application.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the manner in which families who have not returned the CSHCS application within 30 days of invite, are located, how the ones who are located are contacted, the number of attempts to be made when contacting families, the process by which assistance is offered, and how these attempted contacts and successful contacts are to be documented.

Examples of further documentation to meet the requirement, including but not limited to:

- Use of Enrollment Application Not Returned Report and notations of follow-up activities indicating multiple attempts to contact individuals or families.
- On-site interview that indicates how attempts are made to locate families who have not returned the CSHCS application and how assistance is offered.

Evaluation Questions:

- Does the LHD CSHCS program adequately attempt to locate individuals or families who do not return a CSHCS Application within 30 days after being invited to join CSHCS?
- Does the LHD CSHCS program offer assistance with application completion to the families that have been located?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 5.3

LHD CSHCS shall assist clients/families who have received a CSHCS 90-day temporary eligibility period (TEP).

This indicator may be met by:

There is evidence that the LHD CSHCS program contacts families that have a TEP and offers/provides assistance during their 90 day TEP to avoid loss of CSHCS coverage.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how the LHD CSHCS program follows up with those with a TEP, how they are contacted and the number of attempts to be made when contacting families.

Examples of further documentation to meet the requirement, including but not limited to:

- Evidence of the LHD using the Temporary Eligibility Period Report to identify those who may need assistance.
- Dated client chart notation documenting contact with families that have TEP coverage within 30 days of receipt of MDHHS letter.
- Evidence of in-person or over-phone assistance provided to the family to complete the requirement that will extend the CSHCS coverage beyond 90 days.
- On-site interview that indicates how the LHD contacts families who have received a TEP and offers/provides assistance to avoid the loss of CSHCS coverage.

Evaluation Question:

- Does the LHD appropriately assist families in completing the TEP process prior to the 90 day deadline?

Section XII: Children's Special Health Care Services (CSHCS)

MPR 6

The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families.

Reference: *HRSA/MCHB Sec. 501 of Title V of the Social Security Act, MCHB Performance Indicators. Michigan Public Health Code 333.5805.*

Indicator 6.1

LHD CSHCS shall initiate contact to inform CSHCS clients/families of applicable CSHCS and related benefits upon enrollment and as needed according to individual circumstances. Following initial enrollment, CSHCS enrolled families shall be contacted at least annually to provide updated information about the CSHCS program, benefits, assess family needs, and update client information.

This indicator may be met by:

There shall be evidence that, at enrollment, the LHD initiates a contact with CSHCS clients/families and informs them about CSHCS and the CSHCS benefits that are applicable to their circumstances at that time as well as other benefits that might address their needs. There shall also be evidence that the LHD contacts enrolled clients/families at least annually to provide updated information about the CSHCS program, benefits, assess family needs, and update client information.

Documentation Required:

(The first four bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the process for the contact at initial enrollment (who, what, and when) including, but not limited to, general CSHCS program information and a description of CSHCS benefits applicable to the current client/family circumstances, as well as, other related programs/benefits.
- Written policy and procedure delineating the process for annual contact (who, what, and when), which includes at a minimum, updated information about the CSHCS program, benefits, assessment of client/ family needs, and collection of updated client/family information.
- Dated client chart notation or other documentation including staff identifier that the client/family has been informed of the various applicable CSHCS benefits initially and during the annual contact at a minimum.
- Dated client chart notation or other documentation including a staff identifier that the client/family has been contacted at least annually.

Examples of further documentation to meet the requirement, including but not limited to:

- Dated plan of care documenting notification with staff identifier to client/family regarding program benefits and updated information received at least annually.
- Dated "Notice of Action" or other documentation to MDHHS/CSHCS to share updated client/family information as needed.
- On-site interview that indicates how the LHD makes the initial contact and the annual contact with families and how they inform of the required information.

- Copy of the Annual Update packet mailed to families. *Materials should be submitted in advance of the review.*

Evaluation Questions:

- Has the LHD initiated contact with new clients/families?
- Has the LHD made contact with families on an annual basis, at a minimum, to share updated program information, assess client/family needs, and obtain updated client information?
- How does the LHD assess client/family needs annually?

Indicator 6.2

LHD CSHCS shall assist the CSHCS enrolled client/family with needs related to CSHCS care and services as appropriate, for example: adding authorized providers, billing problems, hospice, insurance issues, premium assistance, application to the CSN fund, applications for home care and/or respite services, TEFRA, language interpretation services, and others.

This indicator may be met by:

There shall be evidence that the LHD CSHCS assists enrolled clients/families with their needs related to care and services.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to enrolled clients/families addressing their care and service needs.
- Dated client chart notation documenting the client/family has been assisted with their needs related to care and services and staff identifier.

Examples of further documentation to meet the requirement, including but not limited to:

- Dated notation in client's plan of care documenting the assistance the client/family has identified as needing with their care and services.
- Dated Notice of Action to MDHHS/CSHCS requesting action that addresses the client's/family's needs related to care and services.
- Dated care coordination billing specific to assisting a client/family with their needs related to care and services.
- On-site interview that indicates how the LHD assists enrolled clients/families with their needs related to care and services.

Evaluation Question:

- Does the LHD CSHCS program assist clients and families in regard to their care and service needs?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 6.3

LHD CSHCS program shall facilitate transition for CSHCS enrolled youth, young adults, and their families. When already in contact with the family, the LHD CSHCS program shall begin the transition process by the age of 14, but may begin earlier as appropriate.

This indicator may be met by:

There shall be evidence that the LHD facilitates transition of youth and young adults toward aspects of adult life, including adult health care, work, and independence following the CSHCS guidelines. There shall be evidence that transition processes were begun prior to age 14 if the LHD was already in contact with the family.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to clients who are nearing identified transition ages.
- Dated client chart notation documenting the client has received assistance in preparing to transition toward adulthood and staff identifier.

Examples of further documentation to meet the requirement, including but not limited to:

- Completed Transition Readiness assessment tool, Transfer of Care checklist, or Transition Plan.
- Dated notation in client's plan of care regarding the identified needs of the client/family with transition toward adulthood.
- Dated Notice of Action to MDHHS/CSHCS requesting action that addresses the client's/family's needs related to transition toward adulthood.
- Dated care coordination billing specific to assisting a client/family with transition toward adulthood.
- On-site interview that indicates how the LHD assists in the transition of youth/family.
- Copy of Transition packet mailed to families. *Materials should be submitted in advance of the review.*

Evaluation Questions:

- Does the LHD assist with the transition of clients from youth and young adults toward adulthood?
- Does the LHD CSHCS program assist with transition at transition periods earlier than age 14 when already in contact with the family?
- Can the LHD provide examples of outcomes related to transition?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 6.4

LHD CSHCS shall assist and authorize in-state travel and assist with obtaining authorization for out-of-state travel for CSHCS enrolled families as needed following CSHCS policies and procedures.

This indicator may be met by:

There shall be evidence that the LHD CSHCS is assisting and authorizing in-state travel and assisting with obtaining authorization for out-of-state travel following CSHCS published policy for CSHCS enrolled client/families as needed and guidance in the Guidance Manual.

Documentation Required:

(The first five bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how ride assistance is provided to clients/families in need of in-state transportation.
- Written policy and procedure delineating how to authorize in-state transportation reimbursement for clients/families in accordance with CSHCS published policy and the Guidance Manual.
- Dated client chart notation documenting the client has received in-state transportation assistance and staff identifier.
- Written policy and procedure delineating how assistance is provided to clients/families in need of out-of-state transportation.
- Dated client chart notation documenting the client has out-of-state transportation assistance and includes a staff identifier.

Examples of further documentation to meet the requirement, including but not limited to:

- Dated notation in client's plan of care regarding in-state transportation assistance needs.
- Dated/signed CSHCS Transportation form (Form #MSA-0636) for specific clients.
- Dated and signed notation in client's plan of care regarding out-of-state transportation needs/assistance.

Evaluation Questions:

- Does the LHD assist with and provide authorization for in-state transportation services for clients/families following CSHCS policies and procedures?
- If the LHD has not authorized in-state travel or assisted with obtaining authorization for out-of-state travel, can they explain how they would assist a family through the process?

Section XII: Children's Special Health Care Services (CSHCS)

Indicator 6.5

LHD CSHCS shall assist with funded out-of-state care for CSHCS-enrolled families as needed.

This indicator may be met by:

There shall be evidence that the LHD CSHCS is assisting clients/families as needed with out-of-state care.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating how assistance is provided to clients/families in need of out-of-state care.

Examples of further documentation to meet the requirement, including but not limited to:

- Dated client chart notation documenting the client has received out-of-state care and staff identifier.
- Dated and signed notation in client's plan of care regarding out-of-state care needs/assistance

Evaluation Questions:

- Does the LHD assist with out-of-state care for clients/families as needed?
- If the LHD has not assisted with out-of-state care, can they explain how they would assist a family through the process?

Indicator 6.6

The LHD CSHCS program shall provide Level I and Level II care coordination and make case management available to CSHCS families as needed, according to current CSHCS policies and procedures.

This indicator may be met by:

There shall be evidence that the LHD CSHCS program is providing Level I and Level II care coordination services and making case management services available to clients/families as needed in accordance with current CSHCS policies and procedures.

Documentation Required:

- Written policy and procedure delineating how Level I and Level II care coordination services are provided to clients/families when needed.
- Written policy and procedure delineating how case management services are made available to clients/families when needed.

Section XII: Children's Special Health Care Services (CSHCS)

- Dated client chart notation documenting the client has received Level I or Level II care coordination services or case management services and staff identifier.
- Dated notation in client's plan of care indicating the client has received Level I or Level II care coordination services or case management and staff identifier.
- Dated, client-specific billing indicating Level I and/or Level II care coordination or case management.

Evaluation Questions:

- Does the LHD provide Level I and Level II care coordination to clients/families when needed following CSHCS policy and procedures?
- Does the LHD make case management available to clients/families appropriately?

Section XII: Children's Special Health Care Services (CSHCS)

Addendum 1:

CSHCS reviewers will look for each of the items below to be addressed within policies and procedures. Additional policies and documentation will also be reviewed as relevant. Refer to indicators for procedure requirements.

1. LHD CSHCS staff are trained to assist individuals with CSHCS and their families (Indicator 1.2)
2. LHD CSHCS staff use the CSHCS database regularly and proficiently to securely manage CSHCS PHI (Indicator 2.1)
3. LHD CSHCS staff use the designated electronic communications system to share PHI (Indicator 2.2)
4. LHD CSHCS staff operate according to HIPAA requirements (Indicator 2.4)
5. LHD CSHCS staff offer a private location for families to discuss confidential information (Indicator 2.5)
6. LHD CSHCS staff routinely use the most current Guidance Manual and Medicaid Provider Manual (Indicator 3.1)
7. LHD CSHCS staff obtain family input on local CSHCS operations on a regular basis (Indicator 3.3)
8. LHD CSHCS inform families of their Rights and Responsibilities under CSHCS.
9. Data required for reporting is collected, compiled, and submitted in the format and timeframes specified within the Comprehensive Agreement (CPBC) CSHCS agreement.
10. LHD CSHCS provide outreach to families and the community regarding CSHCS (Indicator 4.1)
11. LHD CSHCS staff disseminate and provide outreach materials to families and communities (Indicator 4.1)
12. LHD CSHCS staff provide referrals for all children and families to other community resources available regardless of CSHCS enrollment (Indicator 4.2)
13. LHD CSHCS staff assist families in applying for other programs (Indicator 4.2)
14. LHD CSHCS staff authorize diagnostic evaluations for potentially eligible clients.
15. LHD CSHCS staff inform and refer families to the Family Center (Indicator 4.4)
16. LHD CSHCS staff assist families with application to CSHCS or other forms as requested (Indicator 5.1)
17. LHD CSHCS staff follow-up with families that have not responded to the invitation to enroll in CSHCS (Indicator 5.2)
18. LHD CSHCS staff follow-up with those in a Temporary Eligibility Period (TEP) (Indicator 5.3)
19. LHD CSHCS staff attempt to locate families prior to the lapse of CSHCS coverage to offer renewal assistance.
20. LHD CSHCS staff contact families at initial CSHCS enrollment to explain program benefits, provide other information as needed, and assist with immediate needs and planning (Indicator 6.1)
21. LHD CSHCS staff contact families at least annually to update information and remind them of program benefits (Indicator 6.1)
22. LHD CSHCS staff provide on-going assistance to enrolled families to address care and service needs (Indicator 6.2)
23. LHD CSHCS staff provide transition services and assistance for clients nearing identified transition ages (Indicator 6.3)
24. LHD CSHCS staff assist families with transportation services with in-state and out-of-state travel (Indicator 6.4)

Section XII: Children's Special Health Care Services (CSHCS)

25. LHD CSHCS staff assist families in need of out-of-state (OOS) medical care (Indicator 6.5)
26. LHD CSHCS staff provide Level I and Level II care coordination services (Indicator 6.6)
27. LHD CSHCS staff make case management services available to clients (Indicator 6.6)