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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 internal 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.

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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.

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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.

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Documentation Required:

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

Evaluation Question:

None.

Indicator 1.8 (Not Scored; Demonstration Public Health 3.0 Indicator for Cycle 9)

A local health department shall engage multiple sectors and community partners to generate collective impact for improving social determinants of health[1] and addressing public health priorities. Collaborative efforts and actions must include various cross-sector and non-traditional partnerships outside the health department and within the community, as defined below (see list under "Documentation Required").

This indicator may be met by:

There are seven listed actions a health department may take to meet the indicator, noted below. A health department must provide evidence that it is meeting **at least three of the seven** actions. Documentation required should be provided and evaluation question answered for each of the actions demonstrated.

1. Developing or building new cross-sector and non-traditional partnerships toward achieving collective impact; and/or
2. Leading community health promotion efforts in partnership with health care systems, clinicians, health insurers, and hospitals; and/or
3. Participating with and supporting community coalitions that examine data, set collective goals, and develop plans to improve health outcomes; and/or
4. Leading or playing a prominent community role in engaging multiple sectors to address determinants of health; and/or
5. Using creative and/or innovative strategies to collectively develop partnerships and impact the greatest health needs of the community; and/or
6. Providing leadership in public health policy development through collaboration with multiple sectors and community partners. This may include serving as a chief health strategist or community convener to drive initiatives including those that foster shared resources, services, goals, and collective action to create or assure conditions that improve the community's health and well-being, such as a community health assessment, environmental assessment, and community health improvement plan in partnership with health systems; and/or
7. Participating in formal or informal academic partnerships to implement and test evidence-based strategies, and/or participating in community-based participatory research.

Documentation Required:

The health department must describe and document its engagement of multiple sectors, non-traditional partners, and community members to improve social determinants of health and address public health priorities. Required documents may include, but are not limited to: policies, plans, assessments, reports, agendas, meeting minutes, participant lists, websites, data sets, briefs, media campaigns, contracts, memorandums of understanding, etc. Documents may include,

[1] "Social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." CDC's Healthy People 2030, accessed 4/14/2025. Social Determinants of Health - Healthy People 2030 | odphp.health.gov

but are not limited to:

a) Description of the multi-sector partnership and its members
b) LHD's prominent role in the partnership
c) Priorities, health needs, and social determinants of health addressed
d) Collaborative process used (key action steps taken, or model used) and duration of the collaboration
e) Frequency and mode of meetings
f) List of partnership resources, assets, and roles/responsibilities (i.e., what each partner is contributing to the effort)
g) Method of implementing actions, responsible parties, and monitoring of progress
h) Outcomes and results of the collective action and cross-sector partnership

The same documents can be used to show evidence of meeting multiple items below.

Cross-sector partners and non-traditional partners may include, but are not limited to: elected officials, law enforcement, correctional agencies, transportation, housing and community development, parks and recreation, planning and zoning boards, school boards, groups representing populations with high risk or poor health outcomes, businesses, industries, non-profit organizations, faith-based organizations, chambers of commerce, civic groups, hospitals, health-care providers, health insurers, environmental groups, economic development, philanthropic groups, social services, neighborhood organizations, nursing homes, academia, and mental health. Special attention must be made to ensure inclusion of those groups who are served by the health department, including groups who experience health and social inequities. Examples include groups or individuals who represent minority health, tribal agencies, community members, service recipients, people with lived experience, etc.

Evaluation Questions:

	This indicator may be met by:	Evaluation Questions
1	Developing or building new cross-sector and non-traditional partnerships toward achieving collective impact.	• How has the LHD developed or built a cross-sector community collaboration coalition or work group with non-traditional partners that addresses community health priorities or other important community health issues? • Can the LHD describe the process for establishing the partnerships and demonstrate outcomes? • What is the impact of the LHD's cross-sector partnership?
2	Leading community health promotion efforts in partnership with health care systems, clinicians, health insurers, and hospitals.	• How is the LHD leading a community health promotion effort in partnership with its local health care system (hospitals, health care providers, FQHCs, health care service insurers, etc.)?
3	Participating with and supporting community coalitions that examine data, set collective goals, and develop plans to improve health outcomes.	• How is the LHD collaborating with and supporting community coalition planning and implementation efforts to improve health outcomes (through data analysis and data sharing; planning activities including establishing goals, objectives, work plans, evaluation, resource and grant acquisition, etc.)?

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	This indicator may be met by:	Evaluation Questions
4	Leading or playing a prominent community role in engaging multiple sectors to address determinants of health.	• How is the LHD leading, participating and/or supporting community multi-sector partnerships. • Has the LHD created, convened, and/or sustained relationships with community organizations (private, public, non- profits) that serve particularly vulnerable population groups? • Can the LHD describe the process for establishing the partnerships and demonstrate outcomes?
5	Using creative and/or innovative strategies to collectively develop partnerships and impact the greatest health needs of the community.	• How is the LHD using creative and/or innovative strategies to develop and sustain partnerships that impact community health priorities?
6	Providing leadership in public health policy development through collaboration with multiple sectors and community partners. This may include serving as a chief health strategist or community convener to drive initiatives including those that foster shared resources, services, goals, and collective action to create or assure conditions that improve the community's health and well-being, such as a community health assessment, environmental assessment, or community health improvement plan in partnership with health systems.	• How did the LHD demonstrate serving as a "Chief Health Strategist" that convened community stakeholders to determine health priorities, develop plans to address health priorities, and evaluate community health outcomes/impacts?
7	Participating in formal or informal academic partnerships to implement and test evidence-based strategies, and/or participating in community-based participatory research.	• Has the LHD developed and can demonstrate formal or informal partnerships with universities or academic organizations to implement evidence-based programs and/or strategies or participate in Community Based Participatory Research?

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Attachment A

MATRIX OF SERVICES OF LOCAL PUBLIC HEALTH

Services	Rule or Statutory Citation	Required = Basic + Mandated + ELPHS				Allowable	Notes
		1	1-A	1-B	1-C	2	
Immunizations	MCL 333.9203; R 325.176; Annual appropriations act (example: P.A. 121 of 2024 Sec. 218 and 1222)	X	X	X	X		
Infectious/ Communicable Disease Control; Reporting (General)	MCL 333.2433; Part 51, MCL 333.5101 *et seq.*; Part 52, MCL 333.5201 *et seq.*; R 325.171 *et seq.*; Annual appropriations act (example: P.A. 121 of 2024 Sec. 218 and 1222)	X	X	X	X		See below for more specific requirements.
STI Control	MCL 333.5117; R 325.174; R 325.175; R 325.177; Annual appropriations act (example: P.A. 121 of 2024 Sec. 218 and 1222)	X	X	X	X		For more on HIV/AIDs, see below.
TB Control	MCL 333.5117; R 325.174; R 325.175; Annual appropriations act (example: P.A. 121 of 2024 Sec. 218)	X	X	X			
Emergency Management – Community Health Annex	MCL 30.410; Annual appropriations act (example: P.A. 121 of 2024 Sec. 218)	X	X	X			Basic Service under annual omnibus appropriations act; Mandated Service if required under Emergency Management Act, MCL 30.401 *et seq.*
Prenatal Care	Annual appropriations act (example: P.A. 121 of 2024 Sec. 218)	X	X				
Family Planning Services for Indigent Women	MCL 333.9131	X		X			
Health Education	MCL 333.2433	X		X			See MCL 333.2237(2) for a definition of "health education."

For technical assistance, please contact Jim Rutherford at 517.230.4095 or RutherfordJ2@michigan.gov

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Services	Rule or Statutory Citation	Required = Basic + Mandated + ELPHS				Allowable	Notes
Nutrition Services	MCL 333.2433	X		X			
HIV/AIDS Services; Reporting, Counseling, and Partner Notification	MCL 333.5114; MCL 333.5114a; MCL 333.5131 MCL 333.5923; R 325.173	X		X			
Care of Individuals with Serious Communicable Disease or Infection	MCL 333.5117; Part 53, MCL 333.5301 *et seq.*; R 325.177	X		X			"Financial liability for care rendered under this section shall be determined in accordance with part 53." MCL 333.51147(4).
Hearing and Vision Screening	MCL 333.9301; R 325.3271 *et seq.*; R 325.13091 *et seq.*; Annual appropriations act	X		X	X		
Public Swimming Pool Inspections	MCL 333.12524; R 325.2111 *et seq.*	X		X			Required if "designated." MCL 333.12524(1).
Campground Inspection	MCL 333.12510; R 325.1551 *et seq.*	X		X			Required if "designated." MCL 333.12510(1).
Public/Private On-Site Wastewater	MCL 333.12751; MCL 333.12757; R 323.2210; R 323.2211	X		X	X		"Alternative waste treatment systems" are regulated by LHD.
Food Protection	MCL 289.3103 *et seq.*; Annual appropriations act	X		X	X		
Pregnancy Tests; Certification Forms	MCL 333.17015(18)	X		X			
Public/Private Water Supply	MCL 333.12701 *et seq.*; MCL 325.1001 *et seq.*; R 325.1601 *et seq.*; R 325.10101 *et seq.*	X			X		
Allowable Services						X	This category includes all permissive responsibilities in statute or rule that happen to be eligible for cost reimbursement.

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Services	Rule or Statutory Citation	Required = Basic + Mandated + ELPHS				Allowable	Notes
Other Responsibilities (Upon Delegation)	MCL 333.2235(1)					X	This category is NOT connected to express responsibilities within statute, but instead refers entirely to pure delegation by the department as allowed. In addition to general provision, the Code allows delegations for specified functions.

MATRIX DEFINITIONS

Name	Citation	Description
1. Required Service	MCL 333.2321(2); MCL 333.2408(1)	- "A basic health service designated for delivery through a local health department [LHD] . . . for the local fiscal year covered by the appropriation"; - "[A] local health service specifically required pursuant to [Part 24] or specifically required elsewhere in state law"; or - Services designated under ELPHS.
1-A. Basic Service	MCL 333.2311; MCL 333.2321(2)	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 omnibus appropriations act and could change annually.
1-B. Mandated Service	MCL 333.2408(1)	The portion of required services that are not basic services but are "specifically required pursuant to [Part 24] or specifically required elsewhere in state law."
1-C. ELPHS	Annual appropriations act (example: P.A. 121 of 2024 Sec. 1222. (1))	Funds appropriated in the MDHHS section of the Omnibus Appropriations Act that are to be prospectively allocated to LHDs 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(1);	"[A] health service delivered [by an LHD] which is not a required service but which [MDHHS] determines is eligible for cost reimbursement."
Omnibus Appropriations Act	Annual appropriations act	Most recent omnibus appropriations act for MDHHS.

Attachment B

SELECTION OF LAWS APPLICABLE TO LOCAL PUBLIC HEALTH (LPH)

Public Health Code (Public Act 368 of 1978, as amended)
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 Departments
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
MCL § 333.5923 – HIV Testing and Counseling Costs
MCL § 333.9131 – Family Planning Services
Part 92 (MCL §§ 333.9201 *et seq.*) – Immunization
Part 93 (MCL §§ 333.9301 *et seq.*) – Hearing and Vision Testing and Screening
MCL § 333.11101 – Reporting of Prohibited Donation or Sale of Blood Products

Part 125 (MCL §§ 333.12501 *et seq.*) – Campgrounds and Public Swimming Pools
Part 127 (MCL §§ 333.12701 *et seq.*) – Water Supply and Sewer Systems
Part 138 (MCL §§ 333.13801 *et seq.*) – Medical Waste
MCL § 333.17015 – Informed Consent

Appropriations (Current as of April 2025: Public Act 121 of 2024)
Sec. 218 – Basic Services
Sec. 1222– Essential Local Public Health Services (ELPHS)

Michigan Office of Attorney General (OAG) 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
OAG, 1989-1990, No. 6650 – LHD procedures for establishing sanitation fees for food service establishments
OAG, 1995-1995, No. 6891 – Application of Administrative Procedures Act of 1969 (APA) to LHD
OAG, 2007, No. 7205 – LHD's authority concerning immunization requirements

Food Law (Public Act 92 of 2000, as amended)
MCL § 289.1109 – Definition of "Local Health Department"
MCL § 289.3103, *et seq.* – Enforcement, Delegation to Local Health Department

Natural Resources and Environmental Protection Act (Public Act 451 of 1994, as amended)
Part 31 (MCL §§ 324.3101, *et seq.*) – Water Resources Protection
Water Resources Protection, Part 22 (R 323.2201, *et seq.*) – Groundwater Quality Rules (on-site wastewater treatment)
Part 117 (MCL §§ 324.11701, *et seq.*) – Septage Waste Services

Land Division Act (Public Act 288 of 1967, as amended)
MCL § 560.105(g) – Preliminary Plat Approvals
MCL § 560.109a – Parcels Less Than One Acre

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MCL § 560.118 – Health Department Approval

Condominium Act (Public Act 59 of 1978, as amended)
MCL § 559.171a – Approval of Condominium Project Not Served by Public Sewer and Water

Safe Drinking Water Act (Public Act 399 of 1976, as amended)
MCL § 325.1016 – Agreements to Administer Act; Public Water Supplies

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.

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MPR 1

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

Reference: *PHAB 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.

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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.

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Indicator 1.4

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?

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MPR 2

Develop and implement quality improvement activities in processes, interventions, and/or services.

Reference: *PHAB Standards 9.1 and 9.2*

Purpose:

The purpose of this measure is to assess the health department's culture of quality, including how quality improvement principles are being addressed across the health department.

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

The agency has engaged the 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.

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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 policies and direction?
- How does the agency keep QI visible and ongoing?

Indicator 2.3

Programs and administrative areas within the agency are using data, partner input, and team knowledge to drive decision-making and evaluate whether changes made have resulted in improvement.

This indicator may be met by:

There are three listed actions a health department may take to meet the indicator. A health department must provide evidence it is meeting **at least one** of the three actions **in three areas, including: one administrative example, one personal health example, and one environmental health example.** The health department can show examples of different actions for each of the program areas, or evidence of the same action in all three areas.

1. Using program data to identify opportunities for improvement or comparing baseline data to data collected after a change has been made; **and/or**
2. Implement a process to capture, analyze, and use input from a variety of partners to inform processes to improve services and outcomes. Partners include, but are not limited to, clients/customers, staff, local governing entity and other departments/agencies; **and/or**
3. Making decisions for moving forward based on the analysis of data, including whether to standardize changes or to implement quality improvement tools/methods to test another change.

Documentation Required:

Required documents may include, **but are not limited to**: evidence of QI implementation and activities, policies, plans, assessments, reports, agendas, meeting minutes, websites, data sets, briefs, media campaigns, customer satisfaction surveys and processes, staff satisfaction surveys and processes, analysis of survey results, other data analyses, etc.

	This indicator may be met by:	Documentation Required:	Evaluation Questions
1	Using program data to identify opportunities for improvement or comparing baseline data to data collected after a change has been made.	Examples of how the program has used data to identify opportunities for improvement	• How are staff using program data and measurement to identify and address areas for improvement?
2	Implement a process to capture, analyze, and use input from a variety of partners to inform processes to improve services and outcomes. Partners include, but are not limited to, clients/customers, staff, local governing entity and other departments/agencies	Examples of how the program has collected and used data from a variety of partners Examples of how the program has utilized partner input to inform quality improvement activities	• How are programs collecting and using customer data from different groups of customers (internal/external)? • Has the program made improvements based on customer data collected?

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	This indicator may be met by:	Documentation Required:	Evaluation Questions
3	Making decisions for moving forward based on the analysis of data, including whether to standardize changes or to implement quality improvement tools/methods to test another change.	Examples of how the program has evaluated whether changes have led to improvement and the actions taken accordingly.	Data and measures tell staff whether the changes made actually led to improvement. • How are staff involved in quality improvement projects assessing whether changes made have resulted in improvement? • What are staff doing with the results of that assessment? • Are improvement efforts ongoing?

Indicator 2.4

Program staff are involved in quality improvement activities, including professional development related to quality improvement.

This indicator may be met by:

There are three listed actions a health department may take to meet this indicator. A health department must provide evidence it is meeting **all three actions**.

1. Program staff are using quality improvement tools and/or methods to address identified opportunities for improvement; and
2. Program staff at all levels are involved in quality improvement activities/projects; and
3. Program staff are participating in available training/technical assistance opportunities in quality improvement.

Documentation Required:

Required documents may include, **but are not limited to**: reports, meeting agendas, meeting minutes, participant lists, QI plans or policies, documentation of quality improvement projects, quality improvement team charter, quality improvement training policies, plans, or materials, etc.

	This indicator may be met by	Documentation Required	Evaluation Questions
1	Program staff are using quality improvement tools and/or methods to address identified opportunities for improvement.	Examples of quality improvement methods or tools used to address identified improvement needs	How are programs using quality improvement tools and/or methods to address identified opportunities for improvement?
2	Program staff at all levels are involved in quality improvement activities/projects.	Documentation of staff involved in improvement activities	Are staff at all levels in the program involved in quality improvement activities and/or projects? How are they involved?
3	Program staff are participating in available training/technical assistance opportunities in quality improvement.	Documentation of training or technical assistance offered Documentation of staff participation in training or technical assistance activities	Are staff provided with opportunities to participate in quality improvement training? Are staff participating in available trainings? Do staff have access to resources for technical assistance in implementing quality improvement projects?

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MPR 3

Build and support a diverse and skilled public health workforce.

Reference: *PHAB Standards 8.1 and 8.2*

Indicator 3.1

A local health department shall ensure a competent public health workforce through assessment of staff competencies and the provision of needs-based staff development opportunities.

This indicator may be met by:

There are seven actions identified which a local health department may use to meet this indicator, listed below. Of these seven, a local health department must show evidence of meeting **at least three**.

The local health department should provide evidence that it is meeting these indicators by providing associated documentation. Documentation and/or evidence may include the items listed in the documentation required section of the following table. Documentation may serve as evidence for more than one of the listed actions. Other documentation not included in the table may also be used as relevant to the local health department.

	This indicator may be met by	Documentation Required	Evaluation Questions
1	Completion of a competency assessment based on/ informed by a nationally adopted set of core competencies. (i.e.: The Council on Linkages Between Academia and Public Health Practice, Core Competencies for Public Health Professionals, etc).	Copies of completed core competency assessments Approved policies outlining timeframes for assessment completion	• What recognized core competencies for staff has the local health department adopted? • How has the local health department assessed staff competencies against the adopted set of competencies? • How frequently is the assessment completed?
2	Completion of a staff engagement survey targeting workplace environment, training needs, etc. that drives departmental training offerings, completed on a routine basis.	Copies of staff engagement or satisfaction surveys completed and associated findings	• How is staff engagement assessed at the health department? • How frequently is it assessed? • Is there an agency policy outlining the assessment process timeline?
3	Documentation that the local health department has developed at least one strategy to address competency gaps identified through a workforce needs assessment.	Copies of staff training needs assessment	• How does the health department annually assess staff training needs? • How has the health department planned to address identified training needs? • Did the health department develop written strategies to address identified needs?
4	Documentation that the local health department has implemented at least one strategy to address competency gaps identified through the workforce needs assessment.	Proposed strategies and implementation timelines	• What assessment-based strategies has the health department implemented? • Did implemented activities align with the developed strategy(ies)?

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	This indicator may be met by	Documentation Required	Evaluation Questions
5	Documentation of annually completed staff trainings, which may include: social determinants of health, cultural diversity, public health ethics, emerging public health issues, etc.	Staff training schedules and/or training roster of participants Training certificates List of staff trainings offered annually Documentation of mentoring programs	• What trainings does the health department require staff to complete annually? • Are staff completing annual trainings?
6	Documentation of Academic partnerships, i.e. Internships, working collaboratively provide or create identified needed training for local health department staff or students, participation in community-based participatory research, etc.	Documentation of relationships with academic institutions, etc. Copy of agency internship handbook	• How does the health department engage with academic institutions? • Describe the internship opportunities provided by the health department. • Is there a defined internship process for the department?
7	Evidence of a completed Workforce Development Plan. Local health departments are encouraged to seek approval of the plan by their local governing entity.	Copy of agency workforce development plan	• Does the health department have an approved Workforce Development Plan, which addresses the capability and capacity of the workforce, includes an environmental assessment, core competencies, annual staff trainings and content, and strategies to address gaps in staff capacity and capabilities? • How is this plan shared with the local governing entity and/or with staff?

Section II: Food Service

MPR 1
Plan Review

Materials necessary for auditing the MPR

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

Sample Selection:

- Use Annex 5 - Office Sample Size Chart and Annex 4 - Approved Random Sampling Methods to determine the number of records for review. For Annex 5 – Office Sample Size Chart, the population size used to determine sample size should encompass full plan reviews that were completed in their entirety.
- Using the logbook, randomly select the records for review for establishments that have been constructed, altered, converted, or remodeled since the last review cycle. The samples selected should encompass full plan reviews that were completed in their entirety. If applicable, at least one Transitory Food Unit (TFU) and/or mobile plan review should be part of the sample. More than one TFU and/or mobile plan review may be part of the sample selection to meet needed sample size.

Program Indicators:

- Plan review file contains the following items:
  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. Documented assessment and approval (e.g. marking as "satisfactory" on plan reviewer's checklist) of proposed equipment.
  g. A copy of the pre-opening evaluation report is in the file.
  h. The evaluation report has a notation to indicate 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; if applicable****
  k. Documented assessment and approval (e.g. marking as "satisfactory" on plan reviewer's checklist) of hot water, dry storage, and refrigerated storage.
  l. Applicant is informed in writing of any deficiencies. All identified deficiencies are addressed in writing, email or a documented phone call or on revised plans.
  m. Plan approval letter is in the file that includes reference to a unique identifier (e.g.: date, location address, specified code number) marked on the approved plans and specifications.
  n. The pre-opening evaluation report is dated either before or on the same day the license is signed.
- An individual plan review file will be considered to meet MPR 1 when ≥ 80% of the required indicators have been met.

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

Section II: Food Service

**Acceptable SOP Documentation:

1. A notation on the plan review checklist to indicate either:
    a. SOPs have been submitted in compliance with the requirements of the Food Code; or
    b. SOPs are not required (construction does not affect operation – e.g. 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.
4. 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 means:

1. Drawings that are proportional between two sets of dimensions (e.g. ¼ 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.

****Use of Plan Reviewer's checklist:

1. For fixed food establishments, the Michigan Department of Agriculture and Rural Development (MDARD) "Fixed Food Establishment Plan Reviewer's Checklist" or any LHD in house created checklist would be acceptable for meeting this indicator.
2. For TFUs and mobiles, the MDARD "Transitory Food Unit (TFU)/Mobile Food Establishment Plan Reviewer's Checklist", MDARD "TFU-Mobile Worksheets and SOP" document, or any LHD in house developed checklist may be utilized to meet this indicator.

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.
- **Met with Conditions** – Between ≤ 79% and ≥ 70% of the establishment files evaluated indicate that the department reviews complete sets of plans and properly documents the plan review process. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met –** Less than 70% of the evaluated plan review files meet the indicators.

Tips for passing MPR 1

- If plan review training is necessary, contact your MDARD Local Health Services Plan Review Specialist.
- Use MDARD's plan review manual, checklists, and other resource materials at: MDARD - Plan Review
- Organize the records to be audited. Arrange the files in chronological order. Discard materials that were either not required to be submitted or used during the review.
- Conduct quality assurance 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 food service establishments is used to evaluate MPRs 2, 4, 6, and 7.
- Use Annex 5 - Office Sample Size Chart and Annex 4 - Approved Random Sampling Methods 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).
- The total sample size should not include more than one mobile food service establishment, and one TFU file for entire LHD jurisdiction.
- Obtain the file for each of the establishments in the sample.

Program Indicators

- Food service establishment has received the required number of evaluations at the proper intervals based upon the frequency for that establishment.
    a. Evaluation frequency is based upon Food Law Act 92 of 2000, Section 3123. However, not all the establishments in the sample require the same number of evaluations. Variations may be due to:
        a. Establishments may have either opened or closed during the three-year review period.
        b. Establishments may be seasonal operations.
        c. Establishments may have been evaluated shortly before the review period thus pushing the first evaluation 6 months back into the review period.
        d. Establishments may be on a risk based evaluation schedule.
        e. The review of evaluation frequency must take these factors into consideration.
    b. A seasonal establishment needs to have one evaluation anytime within each seasonal operational period.
    c. For TFU files, two operational evaluation reports must be present for each licensing year or documentation of why less than two operational evaluations were conducted for a licensing year.
- Evaluation Method:
    a. Determine the number of evaluations that were required and actually conducted on time during the three-year review period. Start with the first evaluation in the review period. To determine if the first evaluation in the review period was conducted on time, it will be necessary to go back to the date of the previous evaluation that occurred just before the first evaluation in the review period. Utilizing the date of the previous evaluation it can then be determined if the first evaluation within the review period was conducted on time.
    b. An LHD may utilize an optional MDARD risk Based evaluation schedule. For those LHDs, evaluation frequencies will be audited utilizing that schedule. See MDARD memo, "Risked Based Evaluation Schedule" dated November 13, 2008.

c. The time between needed evaluations is going to be dependent upon the frequency schedule set for an establishment or if the establishment is a seasonal operation or a TFU.
d. A pre-opening evaluation that is marked "Approved to Open" is considered a routine evaluation.
e. An individual establishment file will be considered to meet MPR 2 when ≥ 80% of the required routine evaluations have been completed at proper frequency.

- Examples 1:
  a. Fixed year-round operating establishment using a six-month evaluation schedule. Identify the first evaluation in the review period. Review the date of the previous evaluation to this first evaluation to decide if this first evaluation was conducted on time. Then from the first evaluation, count forward in the review period in six-month intervals. At each interval, determine if an evaluation was done. Allow one extra month grace period (i.e. 7 months) between evaluations. For the time period under review, determine the percentage of evaluations that were made at the required intervals for the establishment.

Accreditation period: February 10, 2023 – February 10, 2026
Previous Evaluation: October 17, 2022*
*This date is prior to the current review period but is needed to determine if the first evaluation in the current review period is done on time.

First Routine Evaluation: April 20, 2023
- MPR is met; within 7 months from previous evaluation.

Next Routine Evaluation: November 30, 2023
- MPR not met; greater than 7 months from previous evaluation.

Next Routine Evaluation: May 10, 2024
- MPR is met; within 7 months from previous evaluation.

Next Routine Evaluation: Missed – no evaluation done
- MPR not met; an evaluation should have been done within 7 months from previous evaluation; but no evaluation took place.

Next Routine Evaluation: April 30, 2025
- MPR is met; since the previous evaluation was completely missed, restart the frequency.

Next Routine Evaluation: October 12, 2025
- MPR is met; within 7 months from previous evaluation

Would stop the review at this evaluation, since the next upcoming evaluation would roughly occur in March of 2026 which would be outside of the Accreditation time period under view.

Number of required evaluations: 6
Number of evaluations completed: 5
Number of evaluations that were late: 1

Formula:
Subtract the number of routine evaluations completed by the number routine evaluations that were late. Then divide this number by the number of routine evaluations that are required to be done for the time period under review:

5 routines done – 1 routine late = 4 routines
4 routines ÷ 6 routines required to be completed = .67

Frequency percentage rating for this establishment is 67%.
For this individual establishment, MPR 2 would not be met since it is below 80%.

- Example 2:
  a. Fixed year-round operating establishment using a twelve-month risk-based evaluation schedule. Identify the first evaluation in the review period. Review the date of the previous evaluation to this first evaluation to decide if this first evaluation was conducted on time. Then from the first evaluation, count forward in the review period in twelve-month intervals. At each interval, determine if an evaluation was done. Allow one extra month grace period (i.e. 13 months) between evaluations. For the time period under review, determine the percentage of evaluations that were made at the required intervals for the establishment.

     Accreditation period: February 10, 2023 – February 10, 2026
     Previous Evaluation: July 17, 2022*
     *This date is prior to the current review period but is needed to determine if the first evaluation in the current review period is done on time.

     First Routine Evaluation: June 30, 2023
     - MPR is met; within 13 months from previous evaluation.

     Next Routine Evaluation: July 22, 2024
     - MPR is met; within 13 months from previous evaluation.

     Next Routine Evaluation: July 01, 2025
     - MPR is met; within 13 months from previous evaluation.

     Would stop the review at this evaluation, since the next upcoming evaluation would roughly occur in July of 2026 which would be outside of the Accreditation time period under view.

     Number of required evaluations: 3
     Number of evaluations completed: 3
     Number of evaluations that were late: 0

     Formula:
     Subtract the number of routine evaluations completed by the number routine evaluations that were late. Then divide this number by the number of routine evaluations that are required to be done for the time period under review:

     3 routines done – 0 routine late = 3 routines
     3 routines ÷ 3 routines required to be completed = 1

     Frequency percentage rating for this establishment is 100%.
     For this individual establishment, MPR 2 would be met since it is above 80%

- Example 3:
  a. Seasonal establishment which operates for 9 or fewer months each year. Determine if one evaluation was completed during each operating season in the review period. Seasonal establishment evaluations can be done any time throughout the operating season and are not required to be within a certain frequency from the previous evaluation. Determine the percentage of evaluations that were made at the required intervals for the establishment.

     Accreditation Period: February 10, 2023 – February 10, 2026
     Establishment operating period: May – October

     First Routine Evaluation: May 20, 2023
     - MPR is met; evaluation occurred within operational period.

Next routine: September 15, 2024

- MPR is met; evaluation occurred within operational period.

Next routine: June 01, 2025

- MPR is met; evaluation occurred within operational period.

Would stop the review at this evaluation, since the next upcoming evaluation would occur sometime in May to October of 2026 which would be outside of the Accreditation time period under view.

Number of required evaluations: 3
Number of evaluations completed: 3
Number of evaluations that were late: 0

Formula:
Subtract the number of routine evaluations completed by the number routine evaluations that were late. Then divide this number by the number of routine evaluations that are required to be done for the time period under review:

3 routines done – 0 routine late = 3 routines
3 routines ÷ 3 routines required to be completed = 1

Frequency percentage rating for this establishment is 100%.
For this seasonal establishment, MPR 2 would be met since it is above 80%

How to judge compliance with MPR 2

- **Met –** ≥ 80% of the establishment files in the sample meet the evaluation frequency.
- **Met with Conditions –** Between ≤ 79% and ≥ 70% of the establishments in the sample meet evaluation frequency. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met –** Less than 70% of the establishments in the sample meet evaluation frequency.

Tips for Passing MPR 2

- Arrange files in chronological order.
- Plan ahead. Each LHD 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 reviewer can determine frequency compliance. (e.g., marked in the file or in a database, etc.)

Section II: Food Service

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

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 5 – Office Sample Size Chart and Annex 4 – Approved Random Sampling Methods to determine the number of records for review.
- Use the total number of TFE licenses issued over the past three years as the basis for determining sample size.
- 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

- Temporary food service establishment file contains the following items:
  a. 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.
  b. 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 and a copy of Appendix A is attached when needed.
  c. Temporary food establishment license was issued with no unresolved Priority or no more than 2 unresolved Priority foundation violations, deemed by the Director, to not be a risk to food safety.
  d. A violation of Priority or Priority foundation, if any, is designated on the license/evaluation form.
  e. Description of observed violation(s), if any, of Food Law or Michigan Modified Food Code on the license/evaluation form and noted if corrected.
  f. Date of license approval and signature of sanitarian are present on the license/evaluation form.
- An individual TFE file will be considered to meet MPR 3 when ≥ 80% of the required indicators have been met.

*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 in-office consultation with the person in charge can be an in-person meeting, phone call, video call, or other means of communication where the LHD conducted an operational review of the low-risk TFE with the person in charge.

Section II: Food Service

How to judge compliance with MPR 3

- **Met** – ≥ 80% of the licensing records in the sample meet the standards.
- **Met with Conditions** – Between ≤ 79% and ≥ 70% of the licensing records in the sample meet the standard. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 70% of the licensing records in the sample meet the standards.

Tips for passing MPR 3

- Conduct an operational evaluation OR office consultation visit of all temporary food service establishments prior to licensure.
- Use the "Michigan Temporary Food Service Establishment License" form (FI-229).
- Review the application and license/evaluation forms to make certain they are complete and accurate.
- All Priority or more than two Priority Foundation violations must be corrected before issuing a Temporary Food Establishment License.
- Conduct quality assurance reviews of the completed licenses and evaluation forms.

Section II: Food Service

MPR 4
Evaluation Procedures

Materials necessary for auditing the MPR

- The materials and samples used to evaluate MPR 2 are used to evaluate MPR 4.

Program Indicators

- An evaluation report contains the following items:
- 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.
- A summary of what is required by law or code is provided for each violation cited.
- The report is legible.
- 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.
- Verification that copy of evaluation report was given to establishment representative. Examples of verification include, but not limited to, signature of person in charge on report*, documentation that report was e-mailed to establishment, or documentation that report was mailed to facility.
- A pre-opening evaluation that is marked "Approved to Open" is considered a routine evaluation.
- An individual establishment file will be considered to meet MPR 4 when ≥ 80% of the evaluations in that file meet all the indicators.

*Note: If an LHD wants to pursue not having "signature of person in charge on report" as means for verification that copy of evaluation report was given to establishment, the LHD may want to obtain legal review by LHD legal counsel prior to implementing such a policy. Any such review does not need to be available for the Accreditation site visit.

How to judge compliance with MPR 4

- **Met** – ≥ 80% of the establishments in the sample meet the standard.
- **Met with Conditions** – Between ≤ 79% and ≥ 70% of the establishments in the sample meet the standard. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 70% of the 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 (FI-14).
- 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

Sample Selection:

- All staff who conduct routine (operational) inspections, regardless of the risk type of the facility they inspect, are to be included in the "# Inspectors per agency" in the below charts.
- If a LHD has delegated food establishment regulation to another agency (e.g. University) then the staff of this agency are to be included in the "# Inspectors per agency" in the below charts. These individuals would be included in the pool of potential candidates in assessing MPR 5
- Option 1

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

- Option 2

# Inspectors per agency	Establishments visited per agency
1-4	2 Inspections
5-10	4 Inspections
11+	6 Inspections

Program Indicators:

- Show demonstration of risk-based evaluations by a variety of program staff; when possible, each establishment visit must be with a different inspector. Typically, a maximum of one Standardized Trainer who is currently conducting routine inspections may be used. However additional Standardized Trainers may be utilized under certain circumstances such as the prevention of a staff person from having to go out twice for risk-based evaluations in order to meet sample size.
- For Option 1 Accreditation, a list of all staff doing routine inspections, no matter the risk type, shall be provided to MDARD reviewers prior to the audit. The list of inspectors selected to go out with MDARD reviewers will be provided to the LHD no later than the Friday prior to the week of the Accreditation site visit. MDARD will use a random number generator to choose the inspectors being evaluated. MDARD will also chose the establishments for the field review by random numbers. Only high-risk facilities (e.g. Z category) will be chosen for this review.
- For Option 2 Accreditation, the LHD chooses the establishments and staff MDARD reviewers will accompany for demonstration of risk-based evaluations. The establishments chosen shall consist of varying risk levels, providing 50% of the establishments visited are at the highest risk level (e.g., Z category).
- Demonstrate that Risk Factors and Good Retail Practices in the establishments are correctly identified and resolved. MDARD reviewers will use the Accreditation MPR 5 Field Evaluation Worksheet (FEW) for scoring the inspections.

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How to judge compliance with MPR 5

- **Met** – ≥ 80% department compliance with risk-based evaluation methodology during field demonstration.
- **Met with Conditions** – Between ≤ 79% and ≥ 70% department compliance with risk-based evaluation methodology during field demonstration. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 70% department compliance with risk-based evaluation methodology during field demonstration.

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.

MPR 6
Enforcement

Materials necessary for auditing the MPR

- Copy of the local health department's enforcement policy.
- The records and sample used to evaluate MPR 2 and 4 are used to evaluate MPR 6.

Program Indicators

- Determine if the enforcement policy affords notice and opportunity for a hearing equivalent to the Administrative Procedures Act, Act 306 P.A.1969.
- The policy is compatible with Chapter 8 of the 2009 Food Code, and the Michigan Food Law.
- Determine if the LHD's policy has enforcement procedures for addressing unauthorized construction; operating without a license; imminent health hazards; and continuous and recurring violations.
- Verify if the policy has been adopted and signed by the health officer or designee.
- For the time period under review, assess the evaluation reports from the sample of establishments used for MPR 4 to determine if the LHD'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:
- Operation without a license
- Imminent health hazards*
- Continuous Priority and Priority foundation*.
- Recurring Priority, Priority foundation, and Core*.

*See Food Service Program Model Enforcement Guide for Local Health Departments for definitions

How to judge compliance with MPR 6

- **Met** – ≥ 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. Between ≤ 79% and ≥ 70% 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 will result in a "Not Met."
- **Not Met** – Less than 70% 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 6

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

Section II: Food Service

MPR 7
Follow-up Evaluation

Materials necessary for auditing the MPR/ sample selection

- The materials and samples used to evaluate MPR 2, 4, and 6 are used to evaluate MPR 7.

Program Indicator

- A follow-up evaluation shall be conducted by an LHD, 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 and the corrective action appropriately addresses the violation cited. This includes violations that are corrected at the time of evaluation. For evaluations that do not require an onsite follow-up review see the MDARD memo dated 2-17-2015 titled "Guidance for Citation of Violations, Verification of Violation Correction (Follow-ups), Guidance for Confirmation of Correction of Priority foundation Violation Changes Cited in the 2012 Food Law, Evaluation Report Writing, and Issuance of License".
- An approved report form is used to document the results of the follow-up action.
- 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 two 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 7

- **Met** - ≥ 80% of the establishments in the sample meet the standard.
- **Met with Conditions -** Between ≤ 79% and ≥ 70% of the establishments meet the standard. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not met** - Less than 70% of the establishments in the sample meet the standard.

Tips for passing MPR 7

- 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.

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

How to judge compliance with MPR 8

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

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

Tips for passing MPR 8

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

MPR 9

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 5 - Office Sample Size Chart and Annex 4 - Approved Random Sampling Methods to determine the number of records for review.
- 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 stored with the filed complaint record.

How to Judge Compliance with MPR 9

- **Met** – The local health department maintains a consumer complaint tracking system. At least ≥ 80% of the records reviewed indicate the local health department initiates complaint investigations within five working days and documents the findings.
- **Met with Conditions** – The local health department maintains a consumer complaint tracking system. Between ≤ 79% and ≥ 70% of the records reviewed indicate the local health department initiates investigations within five working days and documents the findings. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – The local health department does not maintain a complaint logbook and/or less than 70% of the records reviewed indicate the LHD initiates complaint investigations within five working days, and/or the LHD does not document the findings.

MPR 10

Technical Training of Staff

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 eight designated skill areas:
    a. Public health principles
    b. Communication skills
    c. Microbiology
    d. Epidemiology
    e. Food Law, Food Code, related policies
    f. HACCP
    g. Allergen management
    h. Emergency management
- Employees assigned full time to a food program complete training in these skill areas within 12 months of being assigned to the program. Employees not fully assigned to the food program or part-time employees have 24 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 by verifiable logs, certificates or equivalent.
- Employees that are only involved in the evaluation of specialty food service establishments, MPR 12, are exempt from this training requirement.
- 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 10.

Section II: Food Service

How to Judge Compliance with MPR 10

- **Met** – The training record for each employee indicates that training has been completed in the eight designated skill areas within 12 months from the date of being assigned to the program. Employees who are not fully assigned to the food program or part-time employees have completed training in 24 months.
- **Met with Conditions** - The training record for each employee indicates that training has been completed in the eight designated skill areas, but the training period exceeded 12 months for full time employees or 24 months for the employees who 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 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.

Tips for Passing MPR 10

- Utilize the MDARD Food Service Program Training Guidance

Section II: Food Service

MPR 11

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 that each individual has completed:
    a. 25 joint field evaluations with any other food service program employee who has already completed training under MPR 10 and 11,
    b. 25 independent evaluations under the review (either field or paperwork review) of any other food service program employee who has already completed training under MPR 10 and 11, and
    c. Final five field evaluations with a Standardized Field Trainer.
- Employees assigned full time to a food program complete fixed food service evaluation skills training within 12 months of being assigned to the program. Employees not fully assigned to the food program or part-time employees have 24 months to complete training.
- Logs or equivalent documents are present showing completion of training.
- Employees who are only involved in the evaluation of specialty food service establishments, MPR 12, are exempt from this training requirement.
- 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 11

- **Met** - The training record for each employee, with no previous applicable experience, indicates 25 joint field evaluations and 25 independent evaluations under review have been completed with a food service program employee who has already completed training under MPR 10 and 11; and a final five field evaluations with a Standardized Field Trainer have been completed within 12 months of assignment to the food program. Employees not fully assigned to the food program have completed the training in 24 months.
- **Met with Conditions** – From assignment to the food program, training was completed for the 25 joint field evaluations, 25 independent evaluations under review; and the final five field evaluations with a Standardized Field Trainer, but the training period exceeded 12 months for full-time employees or 24 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 will result in a "Not Met".
- **Not Met** – Either training records are not maintained, or the records indicate the 25 joint field evaluations, 25 independent evaluations under review; or the final five field evaluations with a Standardized Field Trainer have not been completed.

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Tips for Meeting MPR 11

- Utilize the MDARD Food Service Program Training Guidance

MPR 12

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. Specialty food service establishments encompass temporary food service establishments (TFEs), transitory food units (TFU), and mobile food establishments.

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 as having knowledge of the Food Law, Food Code, public health principles, and communication skills. Each employee must be endorsed for each type (TFE, TFU, or mobile) of specialty food service facility they evaluate. Automatic endorsement is received when an employee has met the requirements of MPR 10 and 11.

How to Judge Compliance with MPR 12

- **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 10 and 11.
- **Met with Conditions** - The supervisor endorsement for each newly assigned employee involved in the evaluation of specialty food service establishments is completed, but a newly assigned employee conducted independent evaluations prior to supervisor endorsement. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Supervisor did not evaluate and endorse a newly assigned inspector before conducting independent evaluations for each type of assigned establishment.

Tips for meeting MPR 12

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

MPR 13

Foodborne Illness Investigations- Timely Response

Materials Necessary for Auditing the MPR

- Local health department foodborne illness investigation policy manual
- Foodborne illness 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

- Use the Annex 5 – Office Sample Size Chart and Annex 4 – Approved Random Sampling Methods to determine the number of records for review.

Program Indicators

- Determine if FBI complaint investigations are initiated by the end of the next business day by the person responsible for conducting the investigation . "Initiated" includes the initial contact, phone calls, file reviews, or determination that the complaint is an outbreak*, etc.
- Determine if local health department has promptly reported potential foodborne illness outbreaks to MDARD by forwarding information required on the Form 'A" intake (Pursuant to the Michigan Food Law section 3129 (1)).
- Determine if local health department 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 the Michigan Food Law section 3129(2)).
- Determine if the local health department has submitted a copy of the final written report for foodborne illness outbreaks to the MDARD within 90 days after the investigation has been completed.

*Note: According to MDHHS MPRs under Section III: General CD Control; MDHHS shall be notified within 24 hours of when LHD suspects a communicable disease (CD) outbreak.

How to Evaluate Compliance with MPR 13

- **Met** – ≥ 80% of the foodborne illness investigations records reviewed contain all of the following elements: a) all foodborne illness complaint investigations are initiated by the end of the next business day, b) if applicable, all final written reports are submitted to MDARD within 90 days of investigation completion, and c) if applicable, MDARD notified via FI-238 when source of foodborne disease/poisoning is from MDARD licensed food establishment.
- **Met with Conditions** – Between ≤ 79% and ≥ 70% of the foodborne illness investigations records in the sample meet the standards. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met."
- **Not Met** – Less than 70% of foodborne illness investigation records in the sample meet the standards.

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MPR 14

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

- The records used to evaluate MPR 13 will be used to evaluate MPR 14.

Program Indicators

- Determine if the complaint log or tracking system is systematically reviewed each time a foodborne illness complaint is received to determine if isolated complaints may indicate the occurrence of a foodborne illness outbreak.
- Documentation of the date of the log review and who conducted the review is present. This documentation can occur on, but is not limited to, the complaint intake form A or 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."
    d. Procedures consistent with those described in the International Association for Food Protection publication "Procedures to Investigate a Foodborne Illness, 5th edition or newer, or equivalent procedures (e.g. Council to Improve Foodborne Outbreak Response (CIFOR)).

- Determine if department uses the proper forms for investigating foodborne illness complaints.
    a. For all alleged foodborne illness 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.
- An individual foodborne illness complaint will be considered to meet the standard when ≥ 80% of the required indicators have been met (e.g., four out of five listed indicators are met) for that complaint.

How to Evaluate Compliance with MPR 14

- **Met** – Written foodborne illness standard operating procedures contain at least three of the four required elements AND ≥ 80% of the foodborne illness investigations records in the sample meet the standards.
- **Met with Conditions** – Written foodborne illness standard operating procedures only contains two of the four required elements OR between ≤ 79% and ≥ 70% of the foodborne illness investigation records in the sample meet the standards. This indicator will be required to be met at the next scheduled accreditation evaluation. Failure to meet this indicator will result in a "Not Met.
- **Not Met** – Written foodborne illness standard operating procedures contain one of the four required elements OR less than 70% of the foodborne illness investigation records in the sample meet the standards.

Tips for Passing MPR 13 and 14

- Staff conducting foodborne illness investigations should periodically review the International Association for Food Protection publication "Procedures to Investigate a Foodborne Illness, 5th edition or newer, or equivalent procedures (e.g. Council to Improve Foodborne Outbreak Response (CIFOR).
- 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.
- Review MDARD's FBI memo Foodborne Illness Reporting and Documentation for Minimum Program Requirement (MPR) Compliance

Section II: Food Service

Important Factor 1
Industry and Community Relations

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.

- 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.

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 current employee conducting inspections accumulates 20 contact hours of continuing education for the Accreditation time period under review. 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 current employee assigned to the food service program has accumulated 20 contact hours of continuing education for the Accreditation time period under review.

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.)

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

- Option 1 Accreditation:
  a. LHD has a written quality assurance procedure that addresses doing quality assurance for plan review, TFEs, FBIs, routine evaluations, follow up evaluations, and non-foodborne complaints; and each staff person assigned to the food program has completed three field quality assurance reviews with a Standardized Trainer in the Accreditation time period under review. A LHD that has delegated authority of regulation of food establishments to another agency (e.g., university) would need to include these establishments and staff in the quality assurance review.
  b. The written quality assurance procedure outlines corrective measures that will be taken if deficiencies are found in any of the listed areas or field review.
  c. LHD staff who are only trained in specialty food service operations (MPR 12) are exempt from field quality assurance reviews.
  d. A Standardized Trainer who is currently in good standing automatically meets the field quality assurance review requirements of this Important Factor under Option 1 Accreditation.
- Option 2 Accreditation
- LHD has completed a full self-assessment against the MPRs at least six months before a scheduled site visit; and each staff person assigned to the food program has completed three field quality assurance reviews with a Standardized Trainer in the Accreditation time period under review. An LHD that has delegated authority of regulation of food establishments to another agency (e.g., university) would need to include these delegated establishments in their population size and random sampling for the self-assessment and conduct field quality assurance reviews of the delegated staff.
- LHD staff who are only trained in specialty food service operations (MPR 12) are exempt from field quality assurance reviews.
- A Standardized Trainer who is currently under good standing automatically meets the quality assurance requirements for field of this Important Factor under Option 2 Accreditation.

How to determine compliance with Important Factor IV

- **Met for Option 1 –** A written quality assurance program has been developed and contains elements as listed above under Program Indicators Option 1 Accreditation and documentation is present of the three field quality assurance reviews with a Standardized Trainer for the time period under review.
- **Met for Option 2 –** The LHD has completed a full self-assessment against the MPRs at least six months before scheduled site visit and documentation is presented of the three field quality assurance reviews with a Standardized Trainer for the time period under review.

Important Factor V

20.88 Agreement and National Environmental Assessment Reporting System

Materials Necessary for Auditing Important Factor V

- Documentation of a 20.88 Agreement or enrollment in National Environment Assessment Reporting System (NEARS).

Program Indicators

- The jurisdiction has either a 20.88 Single-Signature Long-Term Food Information Sharing Agreement or is enrolled in NEARS.

How to determine compliance with Important Factor IV

- **MET –** Documentation is present showing jurisdiction has a 20.88 Single-Signature Long-Term Food Information Sharing Agreement or is enrolled in NEARS.

Annex 1 - Corrective Plan of Action

The Michigan Local Public Health Accreditation Program (MLPHAP) requires a formal corrective plan of action (CPA) from a local health department for each MPR indicator that has been found "Not Met" during the on-site review. MLPHAP procedure requires the original CPA to be submitted to the accreditation administrative staff via the Accreditation Web Module.

To expedite review and acceptance by MDARD, via the Accreditation Web Module, LHDs are strongly encouraged to send a copy directly to the MDARD Reviewers (recommend 14 days before due) once the CPA is completed and before submitting to the Accreditation Web Module. The MDARD Reviewers can then provide input on the CPA to ensure it contains all proper elements before the LHD submits and publishes the CPA to the Accreditation Web Module.

Deadline for Submission
The MLPHAP Local Health Departments – Users' Guide states "The timeline for CPA implementation begins at the conclusion of the On-Site Review. CPAs must be entered into the Accreditation Web Module within 60 days of the end of the on-site review. Due to this 60-day deadline, the LHD should send a copy of the CPA to the MDARD Reviewers, recommended 14 days before being due, for input before the end of the 60 days. For more information on the MLPHAP 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 (e.g., less than 70% of the food service establishments are presently being evaluated at the required frequency).
     b. A statement summarizing the standard (e.g., 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, timelines, 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 basis for MDARD to conduct an on-site follow-up to verify that the plan has worked.

2. **Follow-up Review**
   - At least 90 days after a CPA is approved and no longer than one year of the accreditation review; the LHD must submit a written request for the MDARD Reviewers to conduct a follow-up review to demonstrate compliance with the "Not Met" indicators. A minimum of 90 days showing 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:* *

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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

Annex 2 – Corrective Measures (Formerly known as Moot Point)

Corrective Measures
Corrective measures are remedial measures a local health department takes when they detect an MPR deficiency during a review cycle through their normal quality assurance process. The LHD has taken documented action to correct the deficiency and then re-assess to verify the deficiency has been corrected and there is no likelihood that the deficiency will recur.

Option 1 Accreditation and Corrective Measures
For Option 1 Accreditation, corrective measures taken showing the deficiency has been corrected would need to be in place for at least six months prior to the MDARD on-site visit. During the on-site visit, the MDARD would only pull samples for the noted deficient MPR(s) from the time period after implementation of the corrective measures taken by the LHD. The MDARD may request evidence of any corrective measures taken by the LHD.

Option 2 Accreditation and Corrective Measures

- Corrective measures taken **before** the full Option 2 self-assessment of program by local health department.
  - For the full self-assessment, samples of files for an MPR(s) in which corrective measures were taken should be from a time period after implementation of the corrective measures.
  - MDARD may request evidence of any corrective measures taken before the full self-assessment was conducted.
- Corrective measures taken **after** the full Option 2 self-assessment of a program by the LHD.
  - If, during the full self-assessment, the LHD rates themselves as a "Not Met" or "Met with Conditions" for an MPR(s), they may put corrective measures in place and then re-assess to obtain a better rating for the identified MPR(s).
  - This re-assessment, along with the original self-assessment, for the identified MPR(s) would need to be documented and shown to the MDARD during the on-site visit.
  - The corrective measures would need to be in place a minimum of 2 months before re-assessment of the MPR(s). The re-self-assessment would need to be completed before MDARD on-site visit. More than one corrective measure plan can be done for same MPR if time allows and if the first plan implemented does not correct the issue.
  - The MDARD may request evidence of any corrective measures taken.

Annex 3 - 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

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

Field: If MPR 5 receives a Not Met, a CPA and revisit are required. This would entail the MDARD reviewer to accompany and re-evaluate all staff who participated in the Option 1 field review.

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 5 receives a Not Met, a CPA and revisit are required. This would entail the MDARD reviewer 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 5 - Office Sample Size Chart and Annex 4 - 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 to assess progress.
- For review of Field MPRs: MDARD would randomly choose facilities to assign all the staff who participated in initial on-site review.

Section II: Food Service

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

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 4 - 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 (complete population) of the items to be selected (e.g., licensed establishment list, plan review log, complaint log, etc.). If an LHD has delegated authority of regulation of food establishments to another agency (e.g. University) then the food establishment operations that were delegated would need to count toward the overall population size. These delegated establishments would be included in the pool of potential files for assessing MPRs and a proportional sample will be drawn for random selection.

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.

Annex 5 – Office Sample Size Chart

Determine the number of food establishments licensed, full 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. If a an LHD has delegated authority of regulation of food establishments to another agency (e.g., university) then the food establishment operations that were delegated would need to count towards the overall population size and a proportional sample will be pulled from these delegated establishments.

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

Annex 6 - 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 corrective measures. See MPR Indicator Guide, Cycle 9, 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, TFU, etc.). List of specific files selected will be provided during review.
- ❑ Temporary licenses and evaluations for review period.
- ❑ 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.
- ❑ 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, TFU, mobile).
- ❑ Policy and procedure documents relating to:
    - enforcement, including documentation of policy adoption (by whom and date adopted)
    - variances
    - 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
    - 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.
- ❑ II - 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.
- ❑ V – Documentation of 20.88 Agreement or enrollment in NEARS

Annex 7 – Approximate Review Timeline

On-site visits by MDARD Reviewers may take two to five days to complete based on various circumstances such as Accreditation option utilized, travel time, multi-district offices, and number of field visits that need to be conducted. To ensure resources are available during the on-site visit, the LHD should reserve up to five days for the review even though this entire time may not be utilized. Approximately, one month prior to an LHD site visit, the MDARD reviewers shall contact the LHD to discuss an estimated number of days it will take to conduct the review.

NOTES: Multiple offices- When an agency has food program files in multiple offices including sub-contracted offices (e.g., university), all the various records that each office maintains 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.
*For a more complete description of documents needed, see, MPR Guidance Document, Annex 8 - Accreditation Review Document Summary.

ANNEX 8 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 4 was completed 10 months into the next Review period, the On-Site initial Review will be reduced by 10 months for that specific MPR.

Annex 9- Cycle 9 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 MPRs.

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

Option 2 Review Elements

The Review shall consist of the following elements:

- Oral presentation / discussion outlining the food safety program's ongoing.
  - quality assurance activities
  - self-assessment against established MPRs
- Self-assessment document review presented to the MDARD reviewer by the local health department to verify that the self-assessment was completed accurately and properly.
  - The local health department will receive the rating it gave itself on any MPRs, providing the audit verifies the rating as correct.
  - If during the self-assessment, the local health department rates themselves as a "Not Met" or "Met with Conditions" for an MPR(s), they may put corrective measures in place and then re-assess to obtain a better rating for the identified MPR(s).
    - This re-assessment, along with the original self-assessment, for the identified MPR(s) needs to be documented and shown to the MDARD reviewer during the on-site visit.
    - The corrective measures need to be in place a minimum of two months before re-assessment of the MPR(s). The re-assessment would need to be completed before the MDARD on-site visit. More than one corrective measure plan can be done for same MPR(s) if time allows and if the first plan implemented does not correct the issue.
    - MDARD may request evidence of any corrective measures taken.
- 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 reviewer and local health department staff to determine the correct rating.
- The MDARD reviewer may review a significant statistical number based on Annex 5 of the original documents assessed by the LHD to determine if the self-assessment is correct and accurate.
- The self-assessment shall be completed using the MDARD Self-Assessment Guide (MPR 5 does not need to be reviewed).
- MPR 5 Field Review Demonstrations is demonstrated by MDARD reviewer.
- The local health department's quality assurance program will be reviewed by the MDARD reviewer.

Criteria to Qualify for Option 2

All local health departments are encouraged to utilize Option 2. However, a local health department is best prepared to use this option has adequate program resources and is conducting thorough quality assurance program reviews. To qualify for Option 2, the local health department must complete the following:

- Completed a full self-assessment against the MPRs at least six months before scheduled Accreditation site visit; and
- Have a written quality assurance procedure that contains a field review component.

Section II: Food Service

Time Period Under Review for Option 2*

- For LHDs that did not use Option 2 during their previous Accreditation review:
  - Complete the self-assessment covering the first two years of the current review period (two-year total).
    - Example: On-site review is scheduled for March 2027. The normal review period is March 2024 - March 2027. The LHD can start their self-assessment for the MPRs in March of 2026 but must have this self-assessment completed by September of 2026 (six months before schedule site visit) and the self-assessment would cover the time period of March 2024 to March 2026.
- For LHDs that used Option 2 during their previous Accreditation review:
  - Complete the self-assessment covering the last year of the previous review period and the first two years of the current review period (three-year total).
    - Example: On-site review is scheduled for March 2028. The normal review period is March 025 - March 2028. The LHD can start their self-assessment for the MPRs in March 2027 but must have this self-assessment completed by September of 2027 (six months before schedule site visit) and the self-assessment would cover the time period of March 2024 to March 2027.

*Note: Since Cycle 8 Accreditation was a technical assistance review and Option 2 was not utilized in this cycle; all local health departments who pursue Option 2 for Cycle 9 will only have a two-year total for self-assessment. A local health department would not have a three-year period for self-assessment until Cycle 10.

- Self-assessments must be completed no less than six months before the scheduled on-site review date. Completion of a self-assessment less than six months from the scheduled review date will result in the local health department reverting back to Option 1 Accreditation.

Annex 10 - Cycle 9
Accreditation Review Option 2 Application

When you have completed your self-assessment process, e-mail completed application to greens2@michigan.gov. The self-assessment should be completed **one year, but no less than six months**, before the MDARD on-site scheduled accreditation visit. A standalone copy of application can be found at MDARD - Accreditation

Agency Name:

Application completed by (name and title):

Phone:

E-Mail:

Application Date:

Criteria to Qualify for Option 2:
To qualify for Option 2, the local health department must complete the following:

- Completed a full self-assessment against the MPRs at least six months before schedule Accreditation sit visit; and
- Have a written quality assurance procedure that contains a field review component.

Completion Date of Self-Assessment:

If applicable, list any MPR(s) which are initially self-assessed as "Not Met" and the intended date for re-assessment for these MPR(s) after implementation of corrective measures.

MPR#	Re-assessment Date
➢	
➢	
➢	
➢	
➢	
➢	

☐ I verify our Food Program has a written quality assurance procedure and that procedure contains a field review component.

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

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 be able to receive all Communicable Disease (CD) referrals from reporting entities AND maintain relevant, annually reviewed policies and procedures.

This indicator may be met by:

- Maintaining the following policies and procedures for:
  - Receiving case reports from residents, physicians, health care facilities, laboratories, schools, and other reporting entities; **AND**
  - Entering the received reports into the Michigan Disease Surveillance System (MDSS) within one business day; **AND**
- Evidence that policies and procedures for above are adhered to and reviewed annually.

Documentation Required:

- Annual reviewed policies and procedures listed above.
- Documentation indicating the staff responsible for MDSS case entry.
- Documentation indicating how referrals will be received during both business and non-business hours.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following: Communicable Disease (CD)/Nursing Supervisor, Medical Director, or Health Officer.

Evaluation Question:

None

Indicator 1.2

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

This indicator may be met by:

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

For technical assistance, please contact Shannon Johnson (JohnsonS61@michigan.gov) at 517-284-4962 or Tiffany Henderson (HendersonT1@michigan.gov) at 517-284-4949.

- Documentation should also include how data is collected, collated, and analyzed and who within the LHD is responsible for such activities.

Documentation Required:

- The LHD maintains instructions for generation and review of the weekly surveillance log.
- Evidence that surveillance logs are monitored and signed-off on a weekly basis by the CD/Nursing Supervisor, Epidemiologist, or Medical Director. Signatures may be electronic but should include full name and date of review.
- It is highly recommended that weekly analyses are maintained electronically.

Evaluation Question:

None

Indicator 1.3

The local health department shall create routine reports that includes aggregate CD data with interpretation 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 a routine report that can be distributed to interested entities such as community physicians, infection control, and the public.
    - Paper-based or electronic reports should be distributed at least annually and include aggregate data to illustrate the jurisdiction's CD trends.
    - The report should also include an analysis and interpretation of public health data with conclusions drawn from the data. For example, including a narrative about data findings, summarizing disease-specific control efforts, or discussing a specific condition or interest (e.g., local increase in Hepatitis C).
    - If this analysis cannot be included in the agency's annual report, analysis and interpretation of CD data in another report or displayed on the agency's website would meet this indicator.

Documentation Required:

- Annual (or more frequent) report of your jurisdiction's communicable diseases that includes counts or trends plus interpretation.
- List of stakeholders who receive Annual Report/quarterly updates.

Evaluation Question:

None

Section III: General Communicable Disease Control

Indicator 1.3 Special Recognition

Indicator: The local health department disseminates a quarterly (or more frequent) update with similar data as the annual report to community physicians, infection control, and the public.

Documentation: Quarterly (or more frequent) updates or other news bulletins that get disseminated through the local health department's jurisdiction or via a public-facing dashboard.

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 conduct CD investigations as required by Michigan laws, rules, and/or executive orders AND maintain relevant, annually reviewed policies and procedures. The local health department shall electronically submit CD cases and case report forms that are complete, accurate, and timely to MDHHS by utilization of the MDSS.

This indicator may be met by:

- Maintaining the following policies and procedures for:
  - Utilizing MDSS and case report forms for all CD; **AND**
  - Completing 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) in MDSS within 7 days of receipt; **AND**
  - Utilizing disease specific protocols to investigate individual case reports; **AND**
  - Completing cases within the local health department's timeframes; **AND**
  - Filling in, completing, or accounting for at least 90% of the detailed case report form's fields prior to case completion. Information that cannot be obtained should be documented; **AND**
  - Updating, reactivating, or reclassifying MDSS cases as new information is obtained (e.g., lab serogroups and serotype results, patient outcome, and outbreak identification); **AND**
- Evidence that policies and procedures for the above are adhered to and reviewed annually.

Documentation Required:

- Annually reviewed policies and procedures listed above.
- Documentation of how the local health department investigates individual case reports. This includes identifying who initiates the investigation, what action shall be taken, how MDSS is utilized, and the appropriate timelines to be followed.
- Disease specific protocols for select diseases.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following: CD/Nursing Supervisor, Medical Director, or Health Officer.
  Note: Reviewer will pull a random sample of MDSS case reports prior to the Review for evaluation of this indicator. A list of diseases that may be included can be requested from the Reviewer. During this evaluation, evidence of: case completion efforts, reporting timeline requirements, and efforts to update MDSS case report forms as new information is obtained. To meet this indicator, 90% of the cases pulled by the Reviewer (e.g., 18/20) will have to meet the completion criteria listed above.

For technical assistance, please contact Shannon Johnson (JohnsonS61@michigan.gov) at 517-284-4962 or Tiffany Henderson (HendersonT1@michigan.gov) at 517-284-4949.

Section III: General Communicable Disease Control

Evaluation Question:

None

Indicator 2.1 Special Recognition

Indicator: The local health department has an internal review or audit process for improvement of data quality.
Documentation: Provide evidence of internal review process or audit that includes an aspect of data quality improvement.
And/Or
Indicator: The local health department utilizes case management practices for hepatitis C (HCV) cases and linkage to care (i.e., confirmatory HCV RNA testing and/or HCV treatment start).
Documentation: Local health department provides a disease specific follow-up protocol for hepatitis C that utilizes case management practices, including linkage to care.
And/Or
Indicator: The local health department documents the HIV and diabetes statuses of confirmed TB cases.
Documentation: Confirmed TB cases have known HIV and diabetes statuses documented in the MDSS case report form.

Section III: General Communicable Disease Control

Indicator 2.2

The local health department shall investigate suspect or confirmed outbreaks AND maintain relevant, annually reviewed policies and procedures on such investigations.

This indicator may be met by:

- The local health department conducts investigations of CD outbreaks and clusters; **AND**
- Outbreak investigation folder or log, which may include a list of investigated outbreaks and any additional outbreak investigation notes or documents not already attached to the aggregate form; **AND**
- Evidence that policies and procedures for outbreak investigations are reviewed annually.

Documentation Required:

- 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.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following: CD/Nursing Supervisor, Medical Director, or Health Officer.
- 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. Note: As a cross-reference, aggregate case reports marked as outbreaks will be pulled out of MDSS by the Reviewer prior to the Review for evaluation of this indicator.

Evaluation Question:

None

Indicator 2.2 Special Recognition

Indicator: The local health department maintains regular collaboration meetings with CD and environmental health (EH) staff (at least quarterly).
Documentation: Provide evidence (such as agendas) of quarterly CD/EH collaboration meetings.
And/Or
Indicator: The local health department manages large outbreaks or monitoring events using the MDSS Outbreak Management System (OMS).
Documentation: Outbreak file contains evidence that OMS was utilized to manage one or more outbreaks.

For technical assistance, please contact Shannon Johnson (JohnsonS61@michigan.gov) at 517-284-4962 or Tiffany Henderson (HendersonT1@michigan.gov) at 517-284-4949.

Section III: General Communicable Disease Control

Indicator 2.3

The local health department shall notify MDHHS immediately of a suspected CD outbreak in their jurisdiction and provide finalized data for reporting.

This indicator may be met by:

- The local health department notifies MDHHS within 24 hours when their jurisdiction suspects a CD outbreak. Initial notification can be via phone, fax, email, or MDSS (must include an outbreak identifier); **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 (initial notification should include, when available, possible pathogen, source, number ill, facility); **AND**
- The local health department reports all outbreaks into MDSS via the aggregate form within one business day; for non-routine outbreaks, the local health department has a protocol that indicates when to ALSO call or email an MDHHS point of contact (e.g., Regional Epidemiologist); **AND**
- The local health department updates the aggregate MDSS form with final outbreak data prior to marking complete at the end of the outbreak.

Documentation Required:

- Protocol for notifying MDHHS of outbreaks.
- Protocol for reporting outbreaks into the MDSS aggregate report form, including updating the form with final outbreak data prior to marking complete.
- Summary sheet or other documentation illustrating that policies and procedures were reviewed and approved by one of the following: CD/Nursing Supervisor, Medical Director, or Health Officer.

Evaluation Question:

None

Indicator 2.4

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

This indicator may be met by:

- For foodborne or waterborne outbreaks, the local health department completes and submits the CDC 52.14 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.

Section III: General Communicable Disease Control

- In the event that an investigation is still ongoing 60 days post first illness onset date, a preliminary 52.14 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.
    - Notes: Delays in outbreak reporting occur more often when outbreaks are due to illnesses with long incubation periods, or the outbreak was detected later due to additionally reported cases or laboratory information being received.

Documentation Required:

Copies of completed CDC 52.14 forms

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 performs activities necessary for case follow-up and outbreak mitigation, which includes guidance to prevent disease transmission AND maintains relevant, annually reviewed policies and procedures regarding CD control.

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.
- 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, social media postings, or other guidance documents that will assist the local health department with prevention of disease transmission.

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: CD/Nursing Supervisor, Medical Director, or Health Officer.
- Records and/or documentation that demonstrates timely case follow-up, follow-up efforts, and completion/updates of cases in MDSS.
- 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, social media postings, or other guidance documents that will assist the local health department with prevention of disease transmission.

Evaluation Question:

None

For technical assistance, please contact Shannon Johnson (JohnsonS61@michigan.gov) at 517-284-4962 or Tiffany Henderson (HendersonT1@michigan.gov) at 517-284-4949.

Section III: General Communicable Disease Control

Indicator 3.1 Special Recognition

Indicator: The local health department provides communicable disease presentations to educational venues such as conferences or community health education fairs (at least annually).
Documentation: Copies of CD presentations to educational venues such as conferences or community health education fairs.
And/Or
Indicator: The local health department meets with healthcare stakeholders (such as long-term care facilities and hospital infection preventionists) to provide communicable disease updates (at least quarterly).
Documentation: Local health department / healthcare meeting agendas (at least quarterly).

Indicator 3.2

The local health department maintains adequately prepared staff capable of enforcing Michigan law governing the control of CDs.

This indicator may be met by:

- New staff are provided orientation guidance.
- Routine collaboration between CD/EH/EPC staff.
- 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; 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, including MDSS trainings; **AND**
- Attendance (in-person or remote) of the annual MDHHS CD Conference by at least one staff member. Exceptions may apply (e.g., remote attendance is not offered, the LHD is experiencing an outbreak or local emergency, etc.).
- Local health department staff are aware of how to elevate situations that may require legal intervention (such as public health threat to others, quarantine order, or enforcement of reporting requirements).

Documentation Required:

- The local health department has documentation of CD staff (Epidemiologists, Supervisors, and/or Nursing Staff) orientation guidance either in the form of a manual or checklist.
- Annually reviewed policies and procedures that include description of CD/EH/EPC roles and collaboration.
- Local health department has documentation of CD staff participation in professional development activities, conferences, seminars, and/or trainings.

For technical assistance, please contact Shannon Johnson (JohnsonS61@michigan.gov) at 517-284-4962 or Tiffany Henderson (HendersonT1@michigan.gov) at 517-284-4949.

Section III: General Communicable Disease Control

- The documentation for the above indicator may include either a copy of the CEU certificate or a listing of activities attended for a given year, along with the date of the activity.
- Annually reviewed policies and procedures indicating how frontline CD staff notify Health Officer/Medical Director of situations that may require legal intervention.

Evaluation Question:

None

Indicator 3.2 Special Recognition

Indicator: The local health department staff attend relevant public health webinars, trainings or conferences (e.g., Public Health Law Webinars, Annual Tuberculosis Day Conference, health equity or implicit bias trainings).

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 2026

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, pandemic, 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/pandemic 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/pandemic of a vaccine preventable disease reviewed/updated and signed annually.

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/updated and signed and dated 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?

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 Advisory Committee on Immunization Practices (ACIP) and included in 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 ACIP?
- How does the LHD meet the public demand to vaccinate individuals?
- How are clinic hours publicized?
- Are walk-in clients accepted and/or 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.

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 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 reminder/recall efforts.

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

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

Documentation Required:

- Current policy/protocol/operating procedure on LHD reminder/recall.
- Documentation of reminder/recall efforts on a document such as a graph or spreadsheet outlining the number of reminder and/or recall notices sent to LHD clients with 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/texts etc.

- Documentation of ongoing efforts to work with private providers to promote reminder/recall activities (e.g. educational, MCIR-related, Immunization Quality Improvement for Providers (IQIP), or other collaborative efforts.

Evaluation Question:

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

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 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 bi-annually.

Documentation Required:

- Fee schedule.
- Method of notification used to let clients know that immunization fees can be waived for publicly purchased vaccines in policy/protocol/ or operating procedure.
- Documentation of results from patient record (peer) reviews.
- How does the LHD ensure every client is assessed for all ACIP recommended vaccines at every encounter?

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 Immunization Quality Improvement for Providers (IQIP) review?
- How does the LHD perform clinic-based patient record reviews?

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 vaccines are administered have written up-to-date vaccination protocols/standing orders that are easily accessible ~~at~~ to all staff and 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 followed 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 vaccination documentation must contain Federally required elements.

f) All immunization staff have access to client's immunization records.

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 available at each clinic site (i.e., most current CDC Guide to Contraindications to Vaccinations).
- LHD educational materials explaining immunization risks and benefits including VIS at each site.

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

- 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 all ACIP recommended vaccine standing orders and emergency treatment orders signed by the LHD Medical Director?
- Has the LHD adopted the use of outbreak/pandemic vaccines should the need arise?
- 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) LHD staff immunization policy in place for Healthcare workers

c) Personnel who have contact with patients are encouraged to be appropriately vaccinated with all ACIP recommended vaccines.

Documentation Required:

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

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

- 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

- Declinations on file for immunization staff without all ACIP recommended vaccination(s).

Evaluation Questions

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

- Has the Medical Director 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?

- How does the LHD assure proper vaccination of all staff?

- Is the LHD following their immunization requirements for Healthcare workers as stated in their policy?

- 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.)

Section V: Immunization

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 following MDHHS guidance including ages and antigens.
- Efforts to promote adult immunizations in their jurisdiction.

Evaluation Questions:

- 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 and monitoring the use of MCIR in their jurisdiction for all child, adolescent, and adult immunizations?
- How does the LHD identify and address immunization disparity issues within their jurisdiction?
- How does the LHD promote Health Equity in immunizations across the jurisdiction?
- Is the LHD utilizing the MDHHS Immunization dashboards?
- How does the LHD address vaccine hesitancy and immunization misinformation?

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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; MDHHS Current VFC Provider Manual (updated annually); ACIP/VFC Recommendations; Current Comprehensive Agreement MDHHS VFC/IQIP Site Visit Guidance*

Indicator 3.1

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

This indicator may be met by:

a) Annual Enhanced VFC (EVFC) 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 it's 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.

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

- 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 documented twice daily for each of the units used to store vaccine.

- Testing log or chart of monthly monitoring of the LHD alarm system

- Written policy within the Immunization Manual requiring the use of coolers and appropriate coolant in relation to emergency transport of vaccine following the most current CDC guidelines.

- Written policy within the Immunization Manual requiring the use of portable refrigerators/freezers or qualified pack out containers (for example: Cool Cubes, Vericor, TempArmour, or other qualified containers) in relation to planned transport of vaccine following the most current CDC guidelines.

Evaluation Questions:

- Do the EVFC site visit questionnaires, and EVFC 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 refrigerated/frozen vaccines at its own facilities' clinical sites where vaccines are routinely administered?

- 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 an approved Certified Calibrated Digital Data-logging (DDL) or other certified/calibrated temperature monitoring device/system in place in good working order?

- Does the LHD maintain an alarm system connected to every vaccine storage unit? Has the alarm system been tested monthly to assure the safe storage of vaccine?

- 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 readily available 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 review of the data from the Certified Calibrated Digital Data-logging (DDL) or other certified/calibrated temperature monitoring device/system show for the past 90 days temperatures within range at all times, and that the device has been downloaded weekly?

- Does a check of alarm show appropriate settings for the following: current status/settings, Minimum and Maximum temperature readings, power supply with battery backup (depending on type or alarm), appropriate call out phone numbers, and that the alarm system is operational?

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

- There are no vaccine Lost/Waste 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: Current Vaccines for Children Operations Guidelines)**

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 MDHHS 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 has access to informational material in order to educate private providers about the requirements for the VFC Program.

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

f) The local health department documents and reports appropriate follow-up plans resulting from VFC/IQIP site visits in the indicated CDC program(s).

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 the required number of VFC site visits completed for the past 3 years with all follow-up plans addressed. VFC Providers must have a VFC Compliance visit at least every 24 Months. The city of Detroit is expected to visit 100% of their providers annually using Quality Assurance Specialists (QAS) as assigned to Detroit.

- Documentation of IQIP visits and all IQIP 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.

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

- 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/ IQIP site visits with storage and handling issues or other vaccine management issues?

- Does the LHD conduct IQIP visits with the VFC providers in their jurisdiction? Are all follow-ups completed according to the timeline?

- 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?

- Does the LHD run the Loss/Waste Transaction History report monthly and address overdue issues?

- 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 at least one Nurse trained in the MDHHS Immunization Nurse Educator Program?

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 within 10% of the State immunization rate for children who are aged 19 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 19 to 36 months for Flu and COVID.

This indicator may be met by either:

a) A jurisdiction rate within 10% of the State coverage rate from the County Report Cards for the 4:3:1:3:3:1:4 vaccine series for children aged 19-36 months

b) Or an increase of 3% or greater since the last Accreditation review

c) Or evidence of sustained efforts to increase coverage level percentages such as but not limited to ongoing reminder/recall efforts, ongoing outreach into the community, participation in community events, etc…

Documentation Required:

- Evidence of a jurisdiction rate within 10% of the State coverage rate from the County Report Cards for the 4:3:1:3:3:1:4 vaccine series for children aged 19-36 months.

- Written policy/protocol/or operating procedure included in the Immunization Manual to detailing strategies on increasing immunization coverage levels for the 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 in the MCIR for children aged 19-36 months which includes efforts to reach identified pocket of need areas.

- Written policy/protocol/or operating procedures on increasing vaccination during the Respiratory Virus Season for Flu, COVID, and RSV for all eligible residents in the jurisdiction.

- Documentation of all sustained outreach efforts to maintain/increase immunization coverage levels

Evaluation Questions:

- Has there been a 3% or more increase in coverage levels in the MCIR for 4:3:1:3:3:1:4? What efforts have been made to increase immunization coverage levels for children in this age group?
- Does the LHD assess coverage level percentages for Flu, COVID, and RSV for all eligible residents in the jurisdiction?
- What tools are being used to assess coverage level percentages?

Indicator 4.2

The local health department shall monitor and evaluate adolescent immunization coverage levels for children aged 13-17 years 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 evaluates on a monthly basis the MCIR adolescent immunization coverage level reports for children aged 13-17 years 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) doses 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:

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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

- What tools are being used to assess adolescent coverage level percentages for all of the recommended antigens in the jurisdiction?

- What efforts has the LHD conducted to target implementation and completion of the adolescent Meningococcal vaccine series for MenACWY and MenB?

Indicator 4.3

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

This indicator may be met by:

a) There is evidence that 95% 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 Data submission reports for all counties within the jurisdiction for 90 consecutive days prior to the review showing 72-hour data entry compliance.

Evaluation Question:

- Did 95% 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 bookmarked on their computers.
- 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.

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- Evidence of follow-up for non-compliant or delinquent childcare centers and schools which appear on the status reports.

- Evidence of training for school/childcare staff on the use of MCIR SIRS for immunization reporting.

Evaluation Questions:

- Does the LHD update/maintain the childcare and school facility master listings in MCIR/SIRS?

- How does the LHD provide training to school and childcare immunization reporters?

- 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 reporting adverse events to VAERS (VAERS - About Us) using their on-line services.
- Written policy in the Immunization Manual which includes information on reporting adverse events to MedWatch: The FDA Safety Information and Adverse Event Reporting Program | FDA when indicated.

Evaluation Question:

- Does the LHD report through the MedWatch system when indicated?
- 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/MedWatch systems?
- How does the LHD retain the VAERS/MedWatch reports submitted by the LHD staff?

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:

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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 Michigan Vaccine Information Statements (VIS), and changes to Michigan VIS versions 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 Michigan 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 Michigan 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).
- What documentation of immunization is given to the client to inform them of the vaccines that were administered at that visit?

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

For technical assistance, please contact Heidi Loynes at 517-335-8159 or loynesh@michigan.gov or Barbara Day at 313-378-4533 dayb1@michigan.gov

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.

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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.

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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, such as documentation of site denials, variances, appeals, final inspections, violation notices, and compliance status documentation.
- List of administrative rule reviews for preliminary plat, condominium, and/or less than one acre land division reviewed, as applicable.

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 applicable state law or rule, code provisions, or written guidelines or policies.
- Determine if isolation distances to pertinent site features including unplugged water well(s), water well(s), surface water, seasonal high groundwater table are met, or if a justified and documented variance was granted.
- Determine if documentation supporting approvals and rejections follows the requirements of the Administrative Rules for condominiums, subdivisions, and land divisions less than one acre in size.

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 or applicable state law or rule 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 the code or applicable state law or rule provisions, or the written guidelines and/or policies.

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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.
- Inconsistently documenting whether isolation distances to pertinent site features are met without a justified and documented variance.
- Permit documentation identified that code or applicable state law or rule was not followed.
- Preliminary plat, condominium, and/or less than one acre land divisions granted approval without demonstrating suitability pursuant to the applicable state rule.

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 9.
        - The use of a generic descriptor for topsoil would not result in a "Not Met" during Cycle 9.
        - Thickness of each soil horizon to the depth of the boring or excavation.
        - Seasonal high water table
            - Clearly document if absent, and
            - Specific depth when present in the soil profile.

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

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- 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.

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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 or database/document management system with retrievable information.

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.

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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.

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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

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  - 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.

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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 or electronic database system containing results of complaint investigations and documentation of final resolution.

Documentation Required:

- Logbooks, computer database, and/or a filing system for documenting complaints regarding onsite wastewater.
- Sample – Random selection of complaints regarding onsite wastewater.
- Local health department onsite wastewater complaint 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, initial and any ongoing investigation, and final resolution are documented as appropriate.
- Determine that a tracking system exists for complaints regarding onsite wastewater to assure final resolution.
- Identify if staff are uniformly following established policy and procedure.

Evaluating Compliance:

Met – Complaints as received are logged and investigated; an effective tracking system exists which is used to determine current 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, the current status or record of final resolution is not documented in all instances.

Not Met – Complaints as received are not logged and/or not investigated. Complaints are received and logged only when an investigation determined the complaint was valid. The agency policy or actions resulting in closure of a complaint (without resolution or enforcement tracking) where a condition constitutes a public health hazard, nuisance, unsanitary condition, or violation of applicable code, ordinance, and/or regulation.

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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 Environment, Great Lakes, and Energy (EGLE).

*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 EGLE.

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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 EGLE 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 EGLE 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.

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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 EGLE. 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.

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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. See Appendix E. which has been authorized based upon communication with the EGLE. As an example, a number of local health departments have requested and received authorization to utilize a Global Positioning System () 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.

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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 Environment, Great Lakes, and Energy (EGLE), and (3) an annual summary report generated by EGLE and distributed to local health departments.

EGLE 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 EGLE 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 EGLE 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".

EGLE Failed System Data Submission Forms (Non-Residential and Residential) - are the mechanisms that will be utilized to summarize the data collected on the EGLE Failed System Data Collection Forms (or equivalent forms as discussed above) and for the annual submission of failed system data to EGLE. 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 EGLE 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 EGLE that will be distributed to all local health departments. EGLE annual report will summarize all local health department data submissions.

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

EGLE 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

For technical assistance, please contact Tanya Rule at 906-458-3812 or RuleT@michigan.gov

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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: _____

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

EGLE 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 Tanya Rule at 906-458-3812 or RuleT@michigan.gov

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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 Michigan Department of Environment, Great Lakes, and Energy (EGLE) 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 EGLE. 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.

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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".

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

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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

EGLE 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.

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EGLE 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
- Other _____
- Unable to Determine

For technical assistance, please contact Tanya Rule at 906-458-3812 or RuleT@michigan.gov

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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 (inches below grade)**; Totals:**

- ☐ 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

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

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☐ Unsuitable Fill	☐ Dirty Stone	☐ Excess Cover
☐ Lack of Maintenance	☐ Soil Clogging	☐ Unable to Determine

☐ Other: _____

Section VI: Onsite Wastewater Treatment Management

EGLE 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

System Age Totals in Years; Totals:

0 – 5 6 – 10 11 – 15 16 – 20

21 – 25 26 – 30 31 – 40 > 40 Unknown

For technical assistance, please contact Tanya Rule at 906-458-3812 or RuleT@michigan.gov

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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 (inches below grade)**; Totals:**

- ☐ 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

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: _____

For technical assistance, please contact Tanya Rule at 906-458-3812 or RuleT@michigan.gov

Section VII: HIV/AIDS & STI

All Minimum Program Requirements (MPRs) and Indicators listed below must be met in order to pass the HIV/AIDS and STI 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 STI 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 STI screening, treatment, and linkage services in accordance with the Michigan Public Health Code, Michigan Department of Health and Human Services (MDHHS), current CDC guidance, accreditation, and current clinical guidelines.

This indicator may be met by:

- Screening clients for HIV and other STIs.
- Providing risk reduction/prevention counseling and linkage, including for PrEP, in accordance with current CDC guidance.
- Providing STI testing (including HIV) in accordance with client needs and MDHHS criteria.
- Providing HIV testing for all clients screened and/or treated for STIs.
- Providing STI testing for clients testing positive for HIV.
- Providing appropriate HIV and STI treatment or referral, according to current CDC treatment guidelines and current MDHHS policy.
- Assuring accessible clinic hours with low barrier accommodations for symptomatic cases and DIS referrals.

Documentation Required:

- Written clinic-specific protocol and procedures for provision of HIV and STI screening and clinical services which MUST address:
  - Timely admission, examination, and treatment of clients presenting for HIV and STI services.
  - Assessment of client risk for HIV and STIs.
  - Criteria for prioritizing clients for HIV and STI screening.
  - Appropriate STI treatment.
  - Routine provision of HIV testing for clients screened and/or treated for STIs.
  - Provision of STI 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 of staff orientation/training or an annual review on clinic protocol and procedures (such as current training records, orientation checklists, or sign-in sheets).

For technical assistance, please contact Hanya Ombima (OmbimaH@michigan.gov).

Section VII: HIV/AIDS & STI

Evaluation Question:

Are HIV and STI clinical and prevention services responsive to Michigan Public Health Code, MDHHS accreditation, and current quality assurance standards?

Indicator 1.2

Provide court-ordered HIV and STI counseling, testing, and referral services and victim notification activities in accordance with the Michigan Public Health Code, MCL 333.5129, and current MDHHS guidance.

This indicator may be met by:

- Providing HIV and STI counseling, testing, and referral services on the basis of court order and for notification of victims.
- Documentation of timeliness for court-ordered testing.
- Maintaining an active relationship with the local victim advocate.

Documentation Required:

- Court Ordered Testing Policy or written protocol and procedures.
- Evidence of staff orientation and training on court-ordered testing policy and procedures such as training records, orientation checklists, or sign-in sheets.

Evaluation Questions:

- Are court-ordered HIV and STI counseling, testing, and referral services and victim notification services provided in accordance with the Michigan Public Health Code, current MDHHS guidelines and current CDC guidance?
- How does the local health department communicate with the court to ensure the alleged perpetrator has been tested and victim(s) receive results?

Indicator 1.3

Provide HIV and STI education, conduct outreach, and promote services to the community, providers, and community partners.

This indicator may be met by:

- Providing education on clinical services, infection trends, changes in clinical guidance to providers and community partners.
- Conducting regular outreach activities to promote and offer screening and testing services.
- Implementing recruitment and promotional strategies designed to increase awareness and stimulate testing among affected communities.
- Developing and disseminating promotional materials to increase HIV and STI screening, testing, awareness, and education.

Documentation Required:

Written evidence such as:

- Digital materials; press releases, social media posts, provider newsletters, meeting agendas, listservs, or other correspondence with providers and agencies.
- Physical materials; flyers, posters, billboards, and/or brochures.

For technical assistance, please contact Hanya Ombima (OmbimaH@michigan.gov).

Section VII: HIV/AIDS & STI

- Community outreach logs and presentation slides.

Evaluation Questions:

- How does the local health department conduct outreach, education, and promotion of their services to the community, providers, and community partners?
- When was the local health department website last updated?
- What recruitment and promotional strategies are used to increase community awareness of services and stimulate HIV and STI testing?

Section VII: HIV/AIDS & STI

MPR 2

Perform activities necessary to control the spread of HIV and STI; conduct reporting and follow-up of HIV, Stage 3 (AIDS), and STI 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, Stage 3 (AIDS), and STI cases is in compliance with the Michigan Communicable Disease Rules and the Michigan Public Health Code and in accordance with current MDHHS policy and law.

This indicator may be met by:

- Submitting HIV and STI case reports in a timely and appropriate manner.
- Providing education and technical assistance to physicians, laboratories, and other providers regarding the submission of labs, testing, and case report forms.

Documentation Required:

- Case Reporting Policy or protocol and procedures.
- Evidence that staff with responsibility for case reporting have received orientation/training regarding submission of case reports. This 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. May include Memorandums of Understanding (MOUs), Memorandums of Agreement (MOAs), meeting minutes, email, or other communication.

Evaluation Questions:

- Are all HIV, Stage 3 (AIDS), and STI 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, Stage 3 (AIDS), and STI reports, and associated patient and partner 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, Stage 3 (AIDS), and STI reports, records, and data pertaining to HIV and STI testing, treatment, and reporting, pursuant to the Michigan Public Health Code, HIPAA, and program standards issued by MDHHS.
- Ensuring that any records related to investigation of disease are confidential and maintained in accordance with the strictest retention policy (the State of Michigan or the Local Health Department).
- Ensuring policies are in place that protect clients' Personally Identifiable Information (PII) and address situations if there is a data breach.

For technical assistance, please contact Hanya Ombima (OmbimaH@michigan.gov).

Section VII: HIV/AIDS & STI

Documentation Required:

- Written protocol and procedures that address HIV, Stage 3 (AIDS), and STI case reporting and medical record confidentiality, including electronic medical records and laboratory management system reports, if in use.
- Evidence that staff have received appropriate orientation and training on confidentiality protocol and procedures. This 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, Stage 3 (AIDS), and STI 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 accordance with the Michigan Public Health Code and in consideration of current science.

Documentation Required:

- Written policy or protocol and procedures for investigating and responding to situations involving health threats to others.
- Evidence that staff have received and implemented appropriate orientation and training for investigating and responding to situations involving health threats to others. This 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 & STI

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 STIs 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 referrals and linkage to 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 STIs 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 STIs, encourage screening for and treatment of HIV and STIs, support referral and linkages to needed services, and promote health department assisted Partner Services (PS).
- Documenting a high level of completeness of referrals in Aphirm.

Documentation Required:

- Written referral and linkage protocol and procedures which address:
    - Assessment and prioritization of client needs for prevention, treatment, and other services, with high priority given to pregnant persons, 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 STI, 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.
    - Use of CARFs (Client Authorization for Counselor Assistant Referral Forms).
- Evidence that staff has received orientation and training on facilitated referrals. This may include current training records, orientation checklists, or sign-in sheets.
- A current and comprehensive community resource guide and/or 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. This may include MOUs, MOAs, meeting minutes, emails, or other communication.

Section VII: HIV/AIDS & STI

Evaluation Questions:

- Are clients diagnosed with HIV and STIs successfully linked to the necessary 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 using a whole-person approach?

Section VII: HIV/AIDS & STI

MPR 4

Conduct partner services (PS), by referral or through state or local staff, for HIV, syphilis, gonorrhea, and emerging infections.

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/STI Prevention (2011).*

Indicator 4.1

Individuals diagnosed with HIV, syphilis, gonorrhea, and emerging infections 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 and as outlined by Partner Services (including Aphirm).
- Provision of risk reduction/prevention counseling.
- Maintaining staffing adequate to meet PS needs and having a documented plan in place for PS coverage.
- Maintaining relationships, for example, via memoranda of understanding/agreement (MOU/MOA), with health care providers, community-based organizations, and others that provide HIV and STI testing and treatment, in order to facilitate access to health department-assisted PS among clients diagnosed with HIV and STIs.
- Maintaining timely entry of index client(s) and/or identified partner(s) documentation into the designated data system in use (i.e. Aphirm and MDSS), in accordance with current MDHHS policy and in order to facilitate access to health department assisted PS and rapid linkage to care for clients diagnosed with HIV and STIs.

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 persons, acute infections, co-infections, and other high risk or priority populations.
  - Community investigations and the proper documentation of (via Patient Community Template for PS or equivalent form).
  - Use of electronic, social media platforms, dating applications, and other communication strategies for notifying partners (including client notification of partners).
  - Provision of or referral for screening for HIV and STIs, such as completed CARFs, documentation of MOUs or MOAs.
  - Documentation of plan of coverage for PS services.
- Written policies to enable and support local 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. May include current training records, orientation checklists, or sign-in sheets.
- Evidence of staff attending MDHHS recommended trainings.
- Evidence of efficient communication about PS with health care providers, community-based organizations and other providers of HIV and STI testing services. May include meeting agendas or minutes, newsletters, MOUs, or MOAs.

Section VII: HIV/AIDS & STI

Evaluation Questions:

- Are PS activities responsive to Michigan Public Health Code and current MDHHS standards and guidance?
- How are the local health department PS staff using the latest techniques? Such as internet partner services.

Section VII: HIV/AIDS & STI

MPR 5

Implement clinical quality management and evaluation activities to provide efficient and effective evidence-based HIV and STI prevention and treatment services.

Indicator 5.1

Conduct clinical quality assurance activities for HIV and STI testing and treatment services.

This indicator may be met by:

- Adhering to QA for 340B compliance where relevant.
- Providing written protocol and procedures for quality assurance activities associated with HIV and STI prevention and testing services.
- Providing evidence of staff and supervisor participation in training, competencies, and professional development activities.
- Providing record of timely, complete, and accurate device and specimen handling according to clinical quality standards.

Documentation Required:

- Written documentation of or protocol and procedures for quality assurance activities such as;
    - Current training and professional development records (for example: bloodborne, chemical hygiene, security and confidentiality).
    - Orientation checklists.
    - 340B Medication Log.
    - Monthly Rapid Testing QA Logs (Daily Client, Control, Inventory).
    - Valid Test Counselor ID (CTR Mods 1-4, annual competencies, continuing education).
    - Packaging and Shipping Training completion (completed one time only by all staff that is handling specimens).
    - Discordant Result form.
    - Aphirm data submission (reactive result: within 24 hours, non-reactive result: within 7 days).
    - Completion of Annual Challenge panels (proficiencies).

Evaluation Question:

How are (clinical) quality assurance activities routinely conducted?

Indicator 5.2

Continuously monitor, evaluate, and implement data-driven activities to strengthen the quality of HIV and STI prevention, testing and treatment services.

This indicator may be met by:

- Continuously monitoring trend and case data from Aphirm and MDSS.
- Using BHSP-supplied data and dashboard reports to drive program planning and decision making.
- Routinely apply program monitoring and evaluation activities for the purpose of continuous improvement.
- Providing evidence of data-driven quality improvement activities, program and/or strategic planning.

For technical assistance, please contact Hanya Ombima (OmbimaH@michigan.gov).

Section VII: HIV/AIDS & STI

Documentation Required:

- Written Evidence of program improvement activities such as:
  - Use of trend data to trigger adjustment in outreach activities
  - Use of county or local data to inform programmatic decisions
  - Case conferencing that allows for coordinated prevention activities
  - Documentation of quality improvement projects or activities
  - Documentation of process for referral follow up
  - Use of customer satisfaction survey to inform programmatic decisions

Evaluation Questions:

- How does the local health department monitor and evaluate their prevention, testing and treatment services?
- How does the local health department use data to enhance the quality of their services and address gaps?

Section VII: HIV/AIDS & STI

MPR 6

Perform activities to improve population-specific outcomes related to HIV and STI.

Indicator 6.1

Provide inclusive HIV and STI services that are designed with a focus on health equity and use an integrative health approach.

This indicator may be met by:

- Conducting education and outreach activities for priority populations.
- Reviewing and evaluating outcome data by Social Determinants of Health (SDOH).
- Collaborating with multi-sectorial partnerships and community programs and services to address SDOH.
- Using local data on HIV and STI disparities to influence program planning.
- Maintaining an updated and accessible community resource guide.
- Ensure staff receive adequate training on Health Equity topics.

Documentation Required:

- Evidence of:
    - Staff completion of SOGIE training (Inclusive Systems of Care for People with Diverse SOGIE).
    - Outreach or promotion based on local data.
    - Programming to address racial disparity for HIV and STIs.
    - Reviewing outcomes by demographic, etc. (may be met by SHOARS data request).
    - Screening to identify clients with unmet SDOH (social determinants of health) needs.

Evaluation Question:

How is the local health department addressing inequities in the communities it serves (socially, economically, demographically, geographically or by other dimensions of inequality)?

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: Family Planning

MPR 1

Provide Family Planning services following Title X Requirements for provision of services: Services must be voluntary, provided without any coercion, provided in a person-centered manner that protects the dignity of the individual, provided without discrimination, with priority to individuals from low-income families, without residency or referral criteria, with safeguards for the privacy and confidentiality of individuals being served (Tenets of Title X Services)

References: *42 CFR (10-2021 edition) §59.5 (a)(2)-(6); 42 CFR §59.5 (b)(5); 42 CFR §59.10; Health Insurance Portability and Accountability Act of 1996 (HIPAA); The Privacy Act of 1974, 5 U.S.C. § 552a; Elliott-Larsen Civil Rights Act, 1976 PA 453, as amended, MCL 37.2101 to 37.2804, Executive Directive 2019-09*

Indicator 1.1

Voluntary. Services must be provided solely on a voluntary basis, without any coercion to accept services or accept any particular methods of family planning. Acceptance of services must not be made a prerequisite to eligibility or receipt of services or participation in any other program.

See Michigan Title X Family Planning Standards & Guidelines **(8.1; 8.1.A, B, C, D; 19.F.1; 20.A; 29.D.2.e)**

To fully meet this indicator:

- The agency providing family planning services assures that services will be provided:
  - On a voluntary basis **(8.1)**
  - Without coercion to accept services or any particular method of family planning **(8.1.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 or any particular method of family planning and without prerequisite to accept any other service. **(8.1.D; 19.F.1)**
- A voluntary general consent must be obtained prior to receiving any clinical services. All consents are included in the medical record. **(19.F; 19.F.4; 20.A; 20.A.1; 29.D.2.e)**
- Staff have been informed that they may be subject to prosecution under federal law if they coerce or try to coerce any person to accept abortion or sterilization. **(8.1.C)**

Documentation Required:

- Policy and 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 or sterilization.

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 IX: Family Planning

Indicator 1.2

Dignity & Respect. Provide services in a manner that is person-centered and which protects the dignity of the individual.

See Michigan Title X Family Planning Standards & Guidelines **(8.5.2;9.2;13.1;13.4;13.4. A;19.A.1-6;29.D.3e, f)**

To fully meet this indicator:

- The agency provides services in a person-centered manner that protects the dignity of each individual. **(8.5.2; 9.2; 19.A.1-6)**
- Has written policy and/or procedures to assure that services are person-centered and protect the dignity of each individual. **(9.2; 8.5.2; 13; 19. A.1.)**
- Service delivery includes the following: **(19.A.1-5)**
  - Assuring clients are treated courteously and with dignity and respect
  - Addressing the individual preferences, needs and values of all clients
  - Assuring client confidentiality and privacy
  - Providing clients the opportunity to participate in shared decision-making in their care
  - Encouraging clients to voice any questions or concerns they may have
- Provide an explanation of range of available services, and agency fees and financial arrangements. **(19.A.6)**
- Upon request, clients are given access to or provided a copy of their medical record. **(29.D.3.d.e)**
- The agency obtains Michigan Department of Health and Human Service (MDHHS) approval prior to conducting any clinical or sociological research involving Title X clients as subjects. **(13.4)**

Documentation Required:

- Policy and Procedure Manuals
- Medical records
- Bill of rights or other documents outlining patient rights and responsibilities
- Client Satisfaction Surveys

Evaluation Questions:

- Do policies and procedures address treating all individuals with dignity and respect for cultural and social practices, and assure client confidentiality?
- Does the agency have a policy that addresses seeking MDHHS approval prior to conducting research involving Title X clients as subjects.

Indicator 1.3

Non-Discrimination. Projects must provide services in a manner that does not discriminate against any individual based on religion, race, color, national origin, disability, age, sex, number of pregnancies, marital status, partisan considerations, disability or genetic information. Projects must provide services without imposing any residency requirements or requiring the patient be referred by a physician.

See Michigan Title X Family Planning Standards & Guidelines **(9; 9.3; 9.9; 13.1; 13.1.D.1-4;13.5. A.1-2; 19.A.6; 19.F.2)**

To fully meet this indicator:

- The agency has written policies and procedures on non-discrimination in providing services without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, marital status, partisan considerations, disability or genetic information. **(9; 9.3)**

Section IX: Family Planning

- There is a written policy that services are provided without residency requirements or physician referral. **(9.9)**
- 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 (LEP) **(13.1.D. 1-4)**
- Consent forms are language appropriate for individuals with Limited English Proficiency (LEP) or are translated by an interpreter. **(13.1.D.4; 19.C.1; 19.F.3)**
- The agency complies with the Office of Population Affairs FPAR requirements, including a system to assure accurate collection of race and ethnicity data **(13.5.A.3.4)**

Documentation Required:

- Non-discrimination policy, including policy on residency and physician referral
- 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:
  - Entrances are clearly marked and easily accessible.
  - Toilets accessible to people with disabilities?
  - Parking for people with disabilities?
- Does the LEP plan include:
  - A statement of agency's commitment to provide meaningful access to individuals with limited English proficiency (LEP)?
  - A statement that services will not be denied to any individual because of limited English proficiency.
  - A statement that individuals will not be asked or required to provide their own interpreter?
  - Language assistance, oral interpretation, and/or written translation?
  - Providing notice to individuals with limited English proficiency?
  - Routine updating of the LEP plan?
  - Staff training?
- Is there a policy stating there are no residency or physician referral requirements for services?

Indicator 1.4

Priority to Low-income Populations. Provide that priority in the provision of services will be given to individuals from low-income families

See Michigan Title X Family Planning Standards & Guidelines **(5; 8.4; 9.1)**

To fully meet this indicator:

- The agency has written policies and/or procedures to assure that no one 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 **(5; Section 1.B Annual Health Care Plan Guidance)**
- Have policy and/or procedures to ensure that low-income individuals are given priority to receive services **(9.1)**

Section IX: Family Planning

Documentation Required:

- Sliding fee scale
- Non-discrimination policy for ability to pay
- Policy and/or Procedures assure that services are prioritized for low-income individuals

Indicator 1.5

Confidentiality. Projects must have policies, procedures and safeguards to protect client confidentiality. Information obtained about individuals receiving services must not be disclosed without the individual's documented consent, except as required by law or as necessary to provide services to the individual. Information may otherwise be disclosed only in summary, statistical or other form that does not identify the individual. *(from old MPRs 3&11.6)*

See Michigan Title X Family Planning Standards & Guidelines **(10.1.A, B, C; 10.2; 10.3; 19.A. 3; 19.F.1; 21. H.3; 29.D.1.c; 29.D.3.a-f)**

To fully meet this indicator:

- Confidentiality is assured by the following: **(10.1. A., B., C.; 19.A.3; 19.F.1; 29.D.3a)**
  - Confidentiality is assured in agency policy and procedures
  - A confidentiality assurance statement appears in the general consent for services in the medical record.
  - All agency personnel assure confidentiality, such as a confidentiality statement
- The clinic has safeguards to provide for the confidentiality and privacy of clients as required by the Privacy Act. **(10.1,10.2; 29.D.3.a-f)**
- HIPAA regulations regarding personal health information are followed **(29.D.1.c)**
  - Including policy updates to comply with the 2024 HIPAA Final Rule to Support Reproductive Health Care Privacy. **(29.D.I.c.a.i-iii)**
- Systems are in place to keep medical records confidential. **(29.D.1.b.4; 29.D.3)**
- The agency does not disclose personal health information without the client's consent, except as required by law or as necessary to provide services. **(10.2; 29.D.3.c)**
  - Agency general consent informs clients of potential disclosure of health information to a policyholder if the policyholder is someone other than the client. **(10.3; 21.H.3.c)**
  - The agency provides confidential services to minors and observes all state laws regarding mandatory reporting and informs minors of situations of potential disclosure. **(21.H.3.a-c; See under Indicator 9.1**)
- Information collected for reporting purposes is disclosed only in summary or statistical form **(10.3; 29.D.3.c)**

Documentation Required:

- Policy and Procedure Manuals
- Medical records
- General Consent for Services

Evaluation Questions:

- Does the physical layout of the clinic ensure that services are provided in a way that protects confidentiality and privacy?
- Are HIPAA policies and procedures updated to comply with current HIPAA privacy regulations, including the HIPAA Privacy Rule to Support Reproductive Health Care Privacy of 2024?

Section IX: Family Planning

MPR 2

Provide for orientation and in-service training for all project personnel.

References: *42 CFR §59.5 (b)(4); MDHHS Michigan Title X Family Planning Standards & Guidelines; CFR Part 84; 29 CFR Part 1910 Subpart E.*

Indicator 2.1

Staff Orientation and Training. Provide for orientation and in-service training for all project personnel

See Michigan Title X Family Planning Standards & Guidelines (8.5.1.A-D; 8.5.3; 8.5.4; 8.6.1-9; 13.2; 18.B; 29.B.2.d; 29.B.3.a; 29.C; 29.C.3 29. E.2.b)

To fully meet this indicator:

- The current MDHHS Title X Family Planning Standards and Guidelines Manual must be available to staff at each site. **(18.B)**
- 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
  - Staff promotion
  - Staff termination
  - Compensation and benefits
  - Grievance procedures
  - Patient confidentiality
  - Duties, responsibilities, and qualifications of each position
  - Licenses for positions requiring licensure
- Personnel records are kept confidential. **(8.5.1.1)**
- Performance evaluations of program staff are conducted according to the agency personnel policy. **(8.5.1.2)**
- Organizational chart and personnel policies are available to all personnel. **(8.5.1.3)**
- Job descriptions are available for all positions and updated as needed. **(8.5.1.4)**
- 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, including drug control licenses. **(8.5.4; 8.5.4.1; 29.E.2.b)**
- The agency must have written plans, protocols procedures for non-medical emergency situations, such as fire, tornado, bomb, terrorism, etc. **(13.2, 29. C)**
- The agency provides for orientation and in-service training for all program personnel, including staff of sub-recipient agencies and service sites. **(8.6.1,2)**
- The agency provides staff training on Title X Legislative Mandates: encouraging family involvement in the decision of minor clients to seek family planning services and on counseling minors on how to resist being coerced into engaging in sexual activities annually. **(8.6.3)**
- 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, 29.C)**
- The agency provides staff training in optimizing broad access to care and the unique social practices, customs and beliefs of under-served populations of their service area at least every two years. **(8.6.6)**
- The agency provides staff training on content related to mandated reporting and human trafficking, including information on agency policy and procedures on mandatory reporting annually. **(8.6.7)**

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- The agency provides training regarding the nature and safety of pharmaceuticals to clinical staff involved in dispensing medications at least every two years. **(8.6.8; 29.B.2.d; 29.B.4.a)**
- Licensed medical staff providing direct patient care is trained in CPR and have current certification. **(29.C.3; 29.E.2.b)**
- Medical Directors without special training, OB-GYN or experience providing family planning must have a minimum of 4 hours in Family Planning or reproductive health care every 2 years. (Trainings through RHNC or NCTC meet this requirement) **(8.6.9)**

Documentation Required:

- Policies and 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
  - Including drug control licenses for all prescribing providers
- Documentation of staff orientation and in-service training, including:
  - Staff training on optimizing access to care & social practices, customs, and beliefs of the under-served populations in the 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.
  - Staff training on mandatory reporting and human trafficking, including information on agency policies and procedures.
- Documentation of staff continuing education
- Documentation of performance evaluations as required by agency personnel policy

Evaluation Questions:

- Are staff training on counseling of minors and staff training on mandatory reporting and human trafficking conducted annually?
- Does Title X orientation training utilize RHNTC's Title X Orientation training?

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MPR 3

Provide, to 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. Projects must provide for an advisory committee.

Reference: *42 CFR §59.5 (b)(4); MDHHS Michigan Title X Family Planning Standards & Guidelines; CFR Part 84; 29 CFR Part 1910 Subpart E.*

Indicator 3.1

Opportunity for Community Participation, Advisory Committee

See Michigan Title X Family Planning Standards & Guidelines (11.1; 11.1.A; 11.1A.1,2,3; 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 must have a governing board, program specific Family Planning Advisory Council (FPAC) or other appropriate advisory group: **(11.1.A)**
    - The council or board is broadly representative of the population served and includes people knowledgeable about family planning. (**11.1.A.1)**
    - Responsibilities of the council/board must 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:

- Is there documentation that the Governing Board or FPAC meets at least once a year?
- Does Governing Board or FPAC membership broadly represent the community served?
- Does the Governing Board or FPAC roster indicate community representation for each member?

Indicator 3.2

Information and Education (I&E) Advisory Committee

See Michigan Title X Family Planning Standards & Guidelines (12; 12.1; 12.2; 12.3; 12.4.A-H; 12.5)

To fully meet this indicator:

- The agency must have an I & E committee that reviews and approves all informational and educational materials (print or electronic) 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)**

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- I & E committee membership is broadly representative of the community served, in terms of demographic characteristics of the community for which materials are intended. **(12.2)**
- The size of I & E committee is at least five members and up to the number determined needed to reflect the community served. **(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 available to members. **(12.4.A)**
- The I & E committee must consider: **(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 medically accurate and culturally/linguistically appropriate.
  - Determine whether the material is suitable for the population or community served.
- The considerations of materials by I & E committee members must be documented using an approved MDHHS evaluation form. **(12.4.C)**
- I & E committee approval of educational materials requires at least one half of voting members. **(12.4.E)**

- I & E Committee must meet at least once a year or more often as needed**. (12.4.F)**
- The agency must maintain a written record of the determinations and approval process including: **(12.4.G)**
  - Minutes of all meetings, including a record of determinations regarding the materials reviewed
  - Completed evaluation forms or a compiled summary of the evaluations
  - A master listing of approved materials and dates approved
- Staff overseeing work of the I & E Committee must bring previously approved materials for review and/or update at least every three years. **(12.4.H)**
- Federal grant support must be acknowledged in publications produced with family planning grant funds. **(12.5)**
  - Acknowledgement includes the following language, unless the agency has requested and received a waiver for alternate language from MDHHS: "This [publication/program/website, etc.] was supported by the Office of Population Affairs (OPA) of the U.S. Department, of Health and Human Services (HHS) as part of a financial award totaling $XX with XX percentage funded by OPA/OASH/HHS and $XX amount and XX percentage funded by non-government source(s). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by OPA/OASH/HHS, or the U.S. Government. For more information, please visit: https://opa.hhs.gov/."

Documentation Required:

- I & E Committee Roster indicating community representation of each I & E Committee member
- I & E Committee Meeting Minutes
- I & E determinations related to materials, including evaluation forms or a record of individual evaluations
- A Master List of approved materials with dates approved

Evaluation Questions:

- Does the I & E committee review the content of all informational and educational materials to assure the information is correct and appropriate for the intended audience?
- Does I & E committee membership broadly represent the community served?
  - Does not include program staff and prioritizes client and community representation?
- Does the I & E committee roster indicate community representation for each committee member?
- Is there documentation of the determinations of I & E committee members for all materials reviewed including:
  - Meeting minutes
  - Master list of approved materials with dates approved
  - Individual evaluation forms, or a compiled summary of member evaluations?
- Is there acknowledgement of Title X grant funding on publications produced by the project? Does acknowledgement contain the required language and grant award number current at the time of publication?
- Are previously approved materials reviewed or updated at least every three years?

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MPR 4

Provide for opportunities for community education, participation, and engagement to achieve community understanding of the objectives of the program; inform the community of the availability of services; and promote participation in the project by individuals to whom family planning services may be beneficial to ensure access to equitable, affordable, person-centered quality family planning services.

Reference: *42 CFR §59.5 (b)(3)(i-iii).*

Indicator 4.1

See Michigan Title X Family Planning Standards & Guidelines (4; 5; 8.7. A; 11.2;)

To fully meet this indicator:

- The agency must establish and implement planned activities to provide community education programs to inform the community of available services and promote participation by individuals who may be in need of family planning services. **(11.2)**
- The agency must submit an Annual Health Care Plan that includes written plans for:
  - Community education activities
  - Community project promotion activities
  - The agency must include priority populations based on an assessment of community needs in the target groups identified for program promotion activities. **(11.2; 8.7.A; Section I.B. Annual Health Care Plan Guidance)**

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

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MPR 5

Provide for billing and collecting client fees to include the following: Clients with family income at or below 100% of the Federal Poverty Level (FPL) are not charged, except where payment will be made by an authorized third party. Charges will be made for services to clients with family income between 101-250% of FPL in accordance with a schedule of discounts based on ability to pay. Charges to clients with family income that exceeds 250% of FPL will be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services.

References: *42 CFR §59.5 (a)(7)-(9).*

Indicator 5.1

See Michigan Title X Family Planning Standards & Guidelines (8.4; 8.4. A-C; 8.4.1; 8.4.2; 8.4.3; 8.4.4; 8.4.5; 8.4.5.B; 8.4.8 A-B; 8.4.9)

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 must not be denied services or subjected to any variation in quality of services because of inability to pay. **(8.4)**
- Individual eligibility for a discount must be documented on the client's record. **(8.4.A)**
- 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.B)**
- The agency's schedule of discounts must be developed with sufficient proportional increments to assure billing is based on ability to pay. Sub-recipients must use the mandated quartile proportional increments distributed by MDHHS unless they have requested and received an MDHHS approved waiver to use other proportional increments. **(8.4.C)**
- 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 those services. **(8.4.1)**
- The agency has a schedule of discounts that is proportional and based on ability to pay for clients with family incomes between 101% and 250% of the current federal poverty level, **(8.4.2)**
- 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 medical record. **(8.4.3)**
- The agency has a schedule of fees designed to recover the reasonable cost of providing services for clients from families whose income exceeds 250% of federal poverty level, **(8.4.4)**
    - The agency reviews program costs and reassess the fee schedule at least every two years, utilizing the MDHHS Family Planning Program cost analysis tool unless the agency has a waiver to use a different methodology for reviewing costs. **(8.4.4)**
    - The agency has a documented process for determining the costs of providing services and indicates how the schedule of fees is determined to recover reasonable costs of providing services. **(8.4.4)**
- The agency charges minors requesting 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 or fee schedule that is different for minors than the fee schedule for other populations receiving family planning services. **(8.4.5.1)**
- The agency has the capacity to provide a bill for the services to clients who request a bill. **(8.4.8.2)**
- The agency's billing and collections policies include a policy on the "aging" of outstanding accounts. **(8.4.8.2)**
- Voluntary donations are permissible; however, clients must not be pressured to make donations and donations must never be a prerequisite to provision of services or supplies. **(8.4.9)**

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Documentation Required:

- Client records showing eligibility for discount for services
- Billing records
- Proportional sliding fee schedule established using current DHHS Poverty Guidelines
- Written agency policy and procedures for charging, billing, and collecting client fees
- Agency procedure for aging outstanding accounts

Evaluation Questions:

- Does the agency have a written policy that fees are waived for individuals with family incomes above the federal poverty level for "good cause" where, as determined by the site director, they are unable to pay for services?
- Are incidents where fees are waived for good cause documented in the medical record?
- Does the agency have documentation of a cost analysis and reviewed and approved fee schedule process conducted in the past two years?

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MPR 6

Provide that where there is a third party (including a government agency) authorized or legally obligated to pay for services, all reasonable efforts are 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, an agreement required.

Reference: *42 CFR §59.5 (a)(10); 42 CFR §59.5 (a)(8)(I, ii)*

Indicator 6.1

See Michigan Title X Family Planning Standards & Guidelines (8.4.6.; 8.4.6.A; 8.4.7; 8.4.8)

To fully meet this indicator:

- Where there is legal obligation or authorization for third party reimbursement, the agency makes reasonable efforts to obtain third party payment, without application of any discounts. **(8.4.6)**
- With regard to insured clients with income at or below 250% federal poverty level, they are never charged a deductible or co-pay more than they would pay if services were charged based on the schedule of discounts. **(8.4.6.1)**
- Where reimbursement is available from Title XIX or Title XX of the Social Security Act, the agency has written agreements/registration with Title XIX, or XX agencies, for reimbursement. **(8.4.7)**
- The agency makes reasonable efforts to collect charges without jeopardizing confidentiality. **(8.4.8)**
    - Clients are informed of potential disclosure of confidential health information to a policyholder where the policyholder is someone other than the client. **(8.4.6.2)**

Documentation Required:

- Client records showing third party billing and reimbursement for services
- Written policy and/or procedures for charging, billing, and collecting fees from third party payers
- Billing for Title XIX, XX, or XXI and receipts of reimbursements

Evaluation Questions:

- Are agency staff aware of billing and client fee collection policies and procedures?

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MPR 7

Provide that all services purchased for project participants are authorized by the project director or designee on the project staff. Provide that any family planning services provided by contract or similar arrangements with other service providers, are provided in accordance with a plan which establishes rates and method of payment for care. These payments must be made under agreements with rates and payment procedures maintained by the agency. The agency must be prepared to substantiate the rates are reasonable and necessary.

Reference: *42 CFR §59.5 (b)(7,9).*

Indicator 7.1

See Michigan Title X Family Planning Standards & Guidelines (8.3.2; 8.3.3; 8.3.4; 21.B.7; 29.A.4; 29. B.3.b, c, d.)

To fully meet this indicator:

- All services purchased for project participants must be authorized by the project director or their designee on the project staff (**8.3.3)**
- The agency must have proper segregation between requisition, procuring, receiving, and payment functions for pharmaceuticals and supplies. (**29.B.4.b)**
- There must be an inventory system to control purchase, use, and reordering of pharmaceuticals and supplies. **(29.B.4.c)**
- Agencies participating in the 340B Program must have policies and procedures in place to assure 340B program compliance including:
  - Safeguards are in place to assure supplies purchased through 340B are provided only to Title X clients.
  - Medicaid billing procedures are in compliance with Medicaid 340B billing requirements.
  - The agency maintains purchasing and inventory control records in compliance with 340B requirements.
  - The agency maintains current certification through the annual 340B recertification **(29.B.5.a-d)**
- The agency has formal arrangements regarding provision of services and reimbursement of costs for contractual services in place. **(8.3.4)**
- If the agency provides required services by referral, formal arrangements with the referral provider must be in place that include a description of the services provided and includes cost reimbursement information. **(8.3.4; 29.A.4; 21.B.7)**
- If a delegate agency subcontracts for services, a formal agreement must be in place that assures consistency with Title X program requirements, must be identified in the annual plan and must have MDHHS approval. **(8.3.2)**

Documentation Required:

- Policies and procedures
- Records of pharmaceutical requisitions
- Documentation of Inventory system
- Records of equipment purchases over the past three years
- Copies of contractual agreements for family planning services purchased.
- Copies of referral agreements between for providing required services.
- Copies of subcontract agreements

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MPR 8

Provide all core family planning services as outlined in *Providing Quality Family Planning Services (QFP).* These include a broad range of acceptable and effective medically approved family planning methods (including natural family planning methods) and services (including pregnancy testing and counseling; assistance to achieve pregnancy; basic infertility services; STI services; pre-pregnancy health services; and youth-friendly health services); and related preventive health services.

References: *42 CFR §59.5(a)(1); 42 CFR CH. 1 §59.5 (b)(1); 42 CFR §59.5 (a)(5); Providing Quality Family Planning Services; Recommendations of CDC and the US OPA, 2014; Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs, 2024; MMWR/ August 8, 2024 / 73(3);1–77. US Selected Practice Recommendations for Contraceptive Use, 2024 (SPR); MMWR/August 8, 2024/73(4); US Medical Eligibility Criteria for Contraceptive Use, 2024 (MEC); MMWR/Vol.70/No.4 Sexually Transmitted Infection Treatment Guidelines, 2021; Michigan Title X Family Planning Standards & Guidelines*

Indicator 8.1

The agency must provide **Contraceptive Services**, including a **broad range of medically (FDA) approved contraceptive products and natural family planning methods and services.**

See Michigan Title X Family Planning Standards & Guidelines (8.2; 8.2A; 8.2.B; 9.8; 18. A, B; 19. B, C; 19.K.1, 2; 19.L, M; 21; 21.A; 21. A, B, C, D, E, F,G; 29.B.7; 29.D.2.c.4)

To fully meet this indicator:

- The agency provides a broad range of medically approved services, including FDA approved contraceptive products and natural family planning methods, temporary and permanent contraception either on-site or by referral. **(9.8; 18. A; 21)**
- Written protocols and procedures to offer contraceptive services that are current and consistent with national standards of care, including the QFP, must be in place and available at each clinic site. **(18.B; 21; 21.A)**
- Provide that individual education and counseling is offered prior to clients making an informed choice regarding family planning services. **(19.B.C.)**
- Methods provided and for which written protocols must be in place, include: **(21. 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 external condoms)
    - At least one type of long-acting reversible contraceptive (LARC) method is provided, either on site or by paid referral.
    - At least one type of natural family planning method is provided.
    - Education materials and information regarding all methods including:
      - Hormonal contraceptives
      - Abstinence
      - Fertility awareness-based methods
      - Barrier methods
      - LARCs (Intrauterine devices or Implants)
      - Sterilization
      - Emergency contraception
  - Emergency Contraception

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        - Emergency Contraception education and provision or referral are provided as appropriate.
        - A written protocol is in place
    - Permanent Contraception (Sterilization)
        - Education and information regarding sterilization is provided where appropriate.
        - The agency has a list of community providers for referral for sterilization procedures (Paid referrals for sterilization are allowed, but not required)
        - All federal regulations on sterilization are met if the procedure is performed by the agency
- The agency does not provide abortion as a method of family planning and has a written policy that no Title X funds are used to provide or promote abortion as a method of family planning. **(8.2; 8.2A)**
    - The agency follows Title X guidance regarding abortion-related services. **(8.2.B)**
- Clients who are undecided on a contraceptive method are offered information on all methods that can be safely used based on the CDC MEC. **(21.G)**
- Education and information about contraceptive methods is medically accurate, balanced, provided in a person-centered and nonjudgmental manner. **(21.G)**
- 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 medical record**. (21.G; 21.G.3)**
- An informed consent for the procedure is obtained prior to insertion or removal an IUD or implant. **(21.G.9)**
- Medical records of transfer clients receiving prescriptive methods contain: **(29.B.9)**
    - A general consent for services
    - A completed client history that has been reviewed
    - A documented blood pressure (BP), if the client desires a combined hormonal method
    - Documentation of the prescription in the medical record
- Medical history elements required for contraceptive services: **(21.E.1)**
    - Desire for reproductive care
    - Allergies
    - Medications
    - Immunizations (MCIR Registry is strongly recommended)
    - Menstrual history
    - Gynecologic and Obstetrical history
    - Recent intercourse
    - Recent delivery, miscarriage or pregnancy termination
    - Contraceptive use
        - Contraceptive experiences and preferences
        - Partner history (use of contraception, pregnant, has children, miscarriage or termination)
        - Condom use, allergies to condoms
        - Interest in Sterilization if age appropriate
    - Current Infectious or chronic health condition (e.g., hypertension)
    - Characteristics and exposures that might affect the client's medical eligibility criteria (MEC) for contraceptive methods. (e.g., age, postpartum, breastfeeding, chronic conditions, smoking)
    - Social history/risk behaviors
    - Sexual history and risk assessment

  - Mental health
  - Intimate partner violence
- 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 are provided for contraceptive services **(21.F)**
  - For clients seeking a combined hormonal contraceptive method blood pressure screening for hypertension **must** be provided
  - For clients seeking IUD insertion, fitting diaphragm or cervical cap a bimanual exam and cervical inspection **must** be provided.
    - CT and GC testing must be available for clients requesting IUD insertion, if indicated.
  - Cervical Cancer screening and clinical breast exam **must** be provided based on current screening recommendations
  - Chlamydia testing **must** be offered annually for all females < 25 years for sexually active clients females ≥ 25 years with risk factors (infected partner, partner with other concurrent partners, symptoms, history of STI or multiple partners in the last year)
  - For male clients, laboratory tests are not required unless indicated by history.
- Revisits are individualized based on need for education, counseling and clinical care beyond that provided at the visit. **(19.L.1,2; 19.L, M; 29.2.d.3,4)**

Documentation Required:

- Protocol and procedures manual specific to all contraceptive methods services
- Educational materials for all methods
- Access to medical records
- Consent forms used for procedures

Indicator 8.2

Offer **pregnancy testing and counseling services**, including offering pregnant clients the opportunity to be provided information and counseling on options.

See Michigan Title X Family Planning Standards & Guidelines (8.2 A; 9.10; 9.11; 19. K. 1,2; 19.L, M; 24; 24 A-E; 29.D.2.c.4)

To fully meet this indicator:

The agency must:

- Provide pregnancy testing, information and counseling to all individuals in need of this service. **(9.10; 25)**
- Have written protocols and procedures to offer pregnancy testing and counseling services that are current and consistent with national standards of care available at each clinic site **(25)**
- Pregnancy diagnosis services include the following: **(25.A)**
  - General consent for services
  - Desires for SRH services
  - Pertinent medical history
  - risk factors Pregnancy testing (qualitative urine with high sensitivity)
  - Pregnancy test results must be given directly to the client
  - Counseling and referral resource list as appropriate
  - Chlamydia testing must be offered to pregnancy test clients < 25 years of age and to those > 25 years with.
- If a pregnancy test is positive, and if ectopic pregnancy or other pregnancy abnormalities are suspected, immediate referral for diagnosis and treatment **must** occur. **(25.B.4)**
- Pregnant clients are offered information and counseling regarding the following options: **(9.10.a,b; 25.C)**

- Prenatal care and delivery
- Infant care, foster care or adoption services
- Pregnancy termination
- When providing pregnancy options information and counseling, the agency provides neutral, factual information and non-directive, unbiased counseling on each of the options and provides referrals upon request, except with respect to any option(s) about which the pregnant client does not wish to receive information, counseling and referral. **(9.10.c; 25.D)**
- Clients considering or choosing to continue the pregnancy are offered referral for prenatal care and early pregnancy counseling and management within the scope of care. **(25.G)**
- Clients considering or choosing to terminate the pregnancy are offered current information about the legal status of abortion in Michigan and provided a referral upon request.

- Clients with a negative test are offered information about appropriate family planning services. **(25.H, I)**
- Revisits are individualized based on the need for education, further counseling, or repeat testing, contraceptive or preventive health care. **(19.K, L, M)**
- Counseling provided is documented in the client record. **(25.K)**

Documentation Required:

- Protocol and procedures for pregnancy diagnosis and counseling
- Medical records
- Educational materials related to pregnancy
- Current referral lists

Evaluation Questions:

- Are referral lists current and do they include a full range of providers for pregnancy care?
- Is Chlamydia testing incorporated into pregnancy testing visits?

Indicator 8.3

Offer services to Individuals who desire to **achieve pregnancy**.

See Michigan Title X Family Planning Standards & Guidelines (19.L.1,2; 19.M; 23; 23.A,B,C; 23.E.9; 29.D.2.d.3)

To fully meet this indicator:

- Written protocols and procedures for achieving pregnancy that are current and consistent with national standards of care must be available at each clinic site **(23)**
- Assessment includes: **(23.A)**
  - When pregnancy is desired
  - Length of time they have been attempting pregnancy.
    - If less than 1 year, provide counseling on maximizing fertility success
    - If more than 1 year, offer basic infertility services
  - History of pregnancies or infertility
  - Partner engagement and support system issues
- Medical history includes: **(23.B)**
  - Immunizations
  - Medications
  - Present infectious or chronic health conditions
  - Genetic conditions
  - Environmental exposures or risks for both partners, (e.g., smoking, alcohol, Zika risk)
  - Social history/risk behaviors

  - Sexual health risk assessment
  - Mental health
  - Reproductive history
    - History of prior pregnancy/birth outcomes (preterm, cesarean delivery, miscarriage, or stillbirth)
    - Past medical/surgical history that might impair reproductive health
    - Medical conditions associated with reproductive failure that could reduce sperm quality
  - Family history
  - Intimate partner violence
- Physical Assessment includes: **(23.C)**
  - Height, weight, BMI (screen for obesity)
  - Blood Pressure (screen for hypertension)
  - Physical exam as needed to evaluate issues raised by review of systems or complaints raised by the client.
  - STI or pre-pregnancy care screening or referral for infertility or other health services as indicated.
- Client education and counseling must be documented in the medical record. **(23.E.9)**
- Revisits are individualized based on the client's need for education, counseling and clinical care beyond that provided at the visit. **(19.L.1,2; 19.M; 29.D.2.d.3)**

Documentation Required:

- Protocol and procedures for achieving pregnancy
- Client medical records
- Educational materials related to achieving pregnancy
- Current referral list

Indicator 8.4

Offer **basic infertility** services to clients desiring these services. Infertility is defined as the failure of a couple to achieve pregnancy after 12 months or longer of regular unprotected intercourse.

See Michigan Title X Family Planning Standards & Guidelines (19.L.1,2; 19.M; 24; 24.C.1,2. a-p; 24.C.3.a,b; 24.E; 29.D.2.d.3)

To fully meet this indicator:

- The agency offers basic infertility services to clients desiring these services**. (24)**
- Written protocols and procedures to offer basic infertility services are current and consistent with national standards of care. **(24)**
- Evaluation as early as 6 months after regular unprotected intercourse provided for:
  - Females >35
  - History of oligo-amenorrhea
  - Known or suspected uterine or tubal disease or endometriosis
  - Partner known to be sub-fertile
- Medical history elements for both clients include: **(24.C.1,2. a-p)**
  - Reproductive history (methods of contraception, coital frequency and timing, duration of infertility, prior infertility, gonadal toxin exposure, including heat)
  - Past surgeries
  - Previous hospitalizations
  - Serious illnesses or injuries
  - Past infections
  - Medical conditions associated with reproductive failure (e.g., thyroid disorders, hirsutism, diabetes mellites, or other endocrine disorders)
  - Childhood disorders
  - Cervical cancer screening results and any follow-up treatment

  - Medications (prescription and nonprescription)
  - Allergies
  - Social history/risk behaviors
  - Family history of reproductive failures
  - Level of fertility awareness
  - Previous evaluation and treatment results; gravidity, parity, pregnancy outcome(s), and associated complications; age at menarche, cycle length and characteristics, and onset/severity of dysmenorrhea
  - Sexual history (pelvic inflammatory disease, history of/exposure to STIs both partners, problems with sexual dysfunction)
  - Review of systems (symptoms of thyroid disease, pelvic or abdominal pain, dyspareunia, galactorrhea, and hirsutism)
- The following physical examination is offered for both clients if clinically indicated: **(24.C.3.a, b)**
  - physical examination females:
    - Height, weight, and body mass index (BMI) calculation
    - Thyroid examination (i.e., enlargement, nodule, or tenderness)
    - Clinical breast examination (CBE)
    - Signs of androgen excess
    - A pelvic examination (i.e., pelvic or abdominal tenderness, organ enlargement/mass; vaginal or cervical abnormality, secretions, discharge; uterine size, shape, position, and mobility; adnexal mass or tenderness; and cul-de-sac mass, tenderness, or nodularity)
    - STI/HIV testing, as indicated
      - Chlamydia testing must be offered for females < 25 and ≥ 25 with risk factors.
  - physical examination males:
    - Examination of the penis (including location of the urethral meatus)
    - Palpation of the tests and measurement of their size
    - Presence and consistency of both the vas deferens and epididymis
    - Presence of a varicocele
    - Secondary sex characteristics
    - STI/HIV testing, as indicated
    - Semen analysis via unpaid lab requisition should be offered based on client concern
- Revisits are individualized based on the client's need for education, counseling and clinical care beyond that provided at the visit. **(19.L.1,2; 19.M; 29.D.2.d.3)**
  - Clients are referred for further diagnosis and treatment if indicated or requested. **(24.E)**

Documentation Required:

- Protocol and procedure manual
- Infertility educational materials
- Referral provider list

Indicator 8.5

Provide **Sexually Transmitted Infection (STI) Services** to clients desiring these services

See Michigan Title X Family Planning Standards & Guidelines (19. L.1,2; 19.M; 21.F.1.d,e; 26; 26.A,B.C,D,E.I; 29.D.2.d.3)

To fully meet this indicator:

- Written protocols and procedures to offer STI services that are current and consistent with national standards of care must be available at each clinic site **(26)**
- Medical history elements required for STI services clients include: **(26.A)**
  - Allergies
  - Medications

  - Medical conditions
  - Sexual health assessment
  - Intimate partner violence
  - Immunization status
- Physical and Laboratory assessment required for STI services clients include: **(26.B,C; 26.D; 26.E; 26.I; 21.F.1.d, e)**
  - Physical exam as indicated based on history or symptoms
  - Chlamydia (CT) and Gonorrhea (GC) testing must be offered annually to clients with risk factors
    - Chlamydia testing must be offered to females <25 years of age and as indicated by risk factors for females ≥25 years.
- When provided on site, agencies must follow current CDC STI Treatment Guidelines and appropriate follow-up measures. **(26.D)**
- Agency complies with state and local STI reporting requirements. **(26. H.1**)
- Revisits are individualized based on the need for education, counseling and clinical care beyond that provided at the visit. **(19.L.1,2; 19.M; 29.D.2.d.3)**

Documentation Required:

- Protocol and procedure STI manuals
- Access to 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 females 25 and older?

Indicator 8.6

Offer **Pre-pregnancy Health Services** to clients desiring these services

See Michigan Title X Family Planning Standards & Guidelines: **(19.K.1,2; 19.L, M; 22; 22.A, B, C, D; 29.D.c.4**)
.

To fully meet this indicator:

- Written protocols and procedures to offer pre-pregnancy health services that are current and consistent with national standards of care must be available at each clinic site, **(22)**
- Medical history elements required for pre-pregnancy health clients: **(22.A. 1-11)**
  - Reproductive goals
  - Sexual health/risk assessment
  - Reproductive history
    - History of prior pregnancy/birth outcomes (e.g., preterm, cesarean delivery, miscarriage, or stillbirth)
    - Past medical/surgical history that might impair reproductive health (e.g., conditions that could reduce sperm quality, varicocele)
  - Environmental exposures, hazards and toxins (smoking, alcohol, other drugs, Zika risk)
  - Medications
  - Genetic conditions
  - Family history
  - Social history/risk behaviors
  - Intimate partner violence
  - Immunizations (MCIR is strongly recommended)
  - Depression
- The following physical and laboratory assessment must be provided for all pre-pregnancy care clients (**22.C; 22.D)**

  - Height, weight, BMI
  - Blood pressure
  - Laboratory testing must be recommended based on risk assessment
    - Chlamydia testing must be offered to females <25 years of age and as indicated by risk factors for females ≥25 years old or older
- Revisits are individualized based on the need for education, counseling and clinical care beyond that provided at the visit. **(19.L.1,2; 19.M; 29.D.2.d.3)**

Documentation Required:

- Protocol and procedure manual
- Access to medical records
- Educational materials regarding pre-pregnancy care

Indicator 8.7

Offer **Related Preventive Health Services** to all desiring these services

See Michigan Title X Family Planning Standards & Guidelines (28; 28.A, B, C)

To fully meet this indicator:

- Written protocols and procedures to offer preventive health services that are current and consistent with national standards of care must be available at each clinic site. **(28)**
- Clinics must offer/provide and stress the importance of clinical breast exam (CBE) and cervical cancer screening. **(28.A.1,2)**
  - Agencies must comply with current MDHHS Family Planning Breast and Cervical Cancer Screening Protocol. **(28)**
  - 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. **(28)**
- Coordination of care must go through the BCCCNP Coordinator unless other referral/payment arrangements are in place. **(28)**
- Clinics must stress the importance of: **(28.B.1,2)**
  - Screening mammography for females aged 40-64 years as indicated.
  - Screening for females aged 25-64 as appropriate.
- Clinics should conduct a genital examination for young males as indicated. **(28.C.1-3)**

Documentation Required:

- Protocol and procedure manuals
- HIPAA to medical records
- Referral/follow-up logs

Evaluation Questions:

- Are protocols and procedures to offer family planning related preventive health services in place?
- Are the current B3CNP Breast and Cervical Cancer Screening protocols in use?

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MPR 9

Provide family planning and related preventive health services to minors in an adolescent (youth)-friendly manner consistent with Title X legislative mandates.

Reference: *42 CFR §59.5 (a)(1); Legislative mandates in title X appropriations related to services to minors.*

Indicator 9.1

Provide Services for Minor Clients

See: Michigan Title X Family Planning Standards & Guidelines: (8.3.7.C; 9.8; 9.12; 9.12.A, B; 10.1.D; 10.4; 13.5; 13.5.C;17; 19.D.1-5; 21. G; 21.H; 21.H.2; 21.H.3; 21.H.4; 21.H.6)

To fully meet this indicator:

- The agency provides family planning and related preventive health services to minors. **(9; 17)**
- The agency must not require written consent of parents or guardians for the provision of services to minors nor notify parents or guardians before or after a minor has requested and/or received family planning services. **(10.1 D; 19. B.1.a)**
- The agency provides confidential services to minors and has policies and procedures in place to assure compliance with state laws regarding mandated reporting of child abuse, child molestation, sexual abuse, incest and human trafficking. **(8.3.7.C; 9.11.B; 10.4; 13.5.C; 19.B.1; 21.H.3; 21.H.3.1)**
- Minor 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 minor clients about how to prevent pregnancy. **(21.H; 19.B.5)**
- Written protocols and procedures are in place that address counseling for minors, including:
  - Encouraging family participation in the decision of minors to seek family planning services **(9.11.A; 19.B. 2; 21.H.4)**
  - Counseling on how to resist attempts to be coerced into sexual activities **(9.11.A; 19.B.3)**
  - Informing minors that services are confidential, and that in special cases (e.g., child abuse) reporting is required **(19.F.2; 21.H.3.b)**
  - Informing Minors of potential for disclosure of confidential information to policyholders where the policyholder is someone other than the client. **(10.3; 19.F.2; 21.H.3.c)**
  - Education and counseling are documented in the medical record **(21.G; 21.G.3)**
- Confidentiality is never invoked to circumvent reporting requirements for child abuse and neglect. **(10.4)**

Documentation Required:

- Protocols and procedures that address services and counseling for minors.
- Access to medical records of minors to review documentation
- Educational materials that address contraceptives and services to minors.

Evaluation Questions:

- Are policies and procedures in place to comply with mandatory reporting requirements?
- Are policies/procedures in place to inform minors of potential for disclosure of PHI to policyholders where the policyholder is someone other than the client?

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MPR 10

Provide family planning medical services under the direction of a clinical services provider with special training or experience in family planning.

Reference: *42 CFR §59.5 (b)(6)*

Indicator 10.1

Medical direction by a clinical services provider with family planning expertise.

See: Michigan Title X Family Planning Standards & Guidelines: (8.5.4; 8.5.4.A, B; 8.5.5; 8.6.9; 9.6; 18.A, B; 29.A; 29.B.2, 3; 29.E.2.c, e)

To fully meet this indicator:

- The medical director must be a licensed, qualified clinical services provider, with special training or experience in family planning. **(8.5.4)**
  - Where a designated medical director is not specialty trained, OB-GYN or with direct experience providing family planning services to clients, at least 4 hours training specific to family planning or reproductive health every two years is documented. **(8.5.4; 8.6.9)**
- 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.B; 29.A)**
- 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 performing medical functions do so under the protocols and/or standing orders approved by the medical director. **(8.5.5)**
- The medical director directs medical services and participates in quality assurance activities.
  - Medical Audits to determine conformity with agency protocols and must be conducted quarterly by the medical director **(29.E.2.c)**
    - At least 2-3 charts per clinician must be reviewed by the medical director quarterly. **(29.E.2.c.1)**

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
- Documentation of quality assurance medical audits
- Approved protocols and standing orders
- Curricula vitae of medical director

Evaluation Questions:

- Are medical audits regularly performed by the medical director to assure conformity with agency protocols on a quarterly basis?
- Is there documentation of medical director training where it is required?

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MPR 11

Provide for emergency medical management to address medical emergency situations.

Reference: *29 CFR 1910, subpart E; 42 CFR §59.5 (b)(1)*

Indicator 11.1

Medical Emergency/Situations and Equipment and Supplies.

See Michigan Title X Family Planning Standards & Guidelines (19.J, L; 29.A.5; 29.B.7; 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, L)**
- There are protocols and procedures in place for the following on-site medical emergency situations: **(29.C.1)**
  - Vaso-vagal reactions/Syncope (fainting)
  - Anaphylaxis
  - Cardiac arrest
  - Shock
  - Hemorrhage
  - Respiratory difficulties
- Protocols are 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 are in place (**29.C.4)**
- At a minimum each clinical site has the following: **(29.B.7)**
  - 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: **(29.A.5)**
  - Documents that the client was advised of the referral and importance of follow-up
  - Documents that the client was advised of their responsibility to comply with the referral

Documentation Required:

- Protocol and procedure manual
- Evidence of emergency drug and supply maintenance

Evaluation Questions:

- Are Medical Emergency protocols and procedures in place and are staff knowledgeable of these protocols and procedures?
- Are staff knowledgeable of location and maintenance procedures for medical emergency equipment?

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MPR 12

Projects must operate in accordance with federal and state law regarding the provision of pharmaceuticals including, security and record keeping for drugs and devices.

Reference: *42 CFR §59.5 (b)(1); PA 368 Sec. 333.17745, 333.17745a, 333.17747.*

Indicator 12.1

Pharmaceuticals/ Prescriptions

See Michigan Title X Family Planning Standards & Guidelines (19.J.1,2; 21.B.6; 21.B.11; 29.B; 29.B.2.a, b, c; 29.B.4.d, e, f; 29.B.5; 29.B.6; 29.B.7; 29.C.1,4)

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)**
- Prescribing, dispensing or delegating dispensing of prescription medications at clinical service sites must be done by a clinical services provider holding a Drug Control License for each clinic location where the storage and dispensing of pharmaceuticals occur. **(8.5.4.1; 29.B.2)**
- Dispensing prescribers only dispense drugs to their clients, with the exception of dispensing prescriptions for expedited partner therapy (EPT) as authorized under Michigan law. **(29.B.3)**
- All medications dispensed in Title X clinics must be pre-packaged. **(29.B.2.a)**
- All prescriptions dispensed (including samples) must be labeled with the following: **(29.B.2.b)**
  - Name/address of clinic location
  - Date of prescription
  - Name of the client, unless prescription is authorized for EPT
  - Name, strength, quantity of drug dispensed
  - Directions for use, including frequency of use
  - Prescriber's name
  - Expiration date
  - Client 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.K.1,2; 29.B.2.c)**
- Sub-recipients must have adequate controls over access to medications and supplies, including. **(29.B.4.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.
- Sub-recipient has policies and procedures in place to assure 340B Program compliance: **(29.B.5.a-d)**
  - Safeguards are in place to assure supplies purchased through 340B are provided only to clients of the family program.
  - Medicaid billing procedures are in place to guard against duplicate discounts.
  - Agency maintains purchase and inventory control records that document compliance with 340B requirements.
  - Agency current 340B certification for each clinical site.
- A formulary, current listing of all drugs available for within the Title X program, must be maintained and reviewed at least annually that includes: **(29.B.5; 21.B.6)**
  - Methods available on site
  - Methods available on site within two weeks

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  - 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; 29.B.7)**
- 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.8; 29.C.4)**
- A system must be in place to monitor expiration dates and ensuring disposal of all expired drugs, including drugs for medical emergencies. **(29.B.4.e; 29.C.4)**
- There must be a system in place for silent notification in case of drug recall. **(29.B.4.f)**
- Writing of prescriptions follows the MDHHS policy including: **(3.F;21.B.8,11; 29.B)**
  - Prescriptions may be written for clients who choose and can obtain their method of choice and medications from a pharmacy.
  - Prescriptions or a referral must be provided for clients whose method of choice is unavailable at the service site.
  - Accepting a written prescription must not pose a barrier for the client.

Documentation Required:

- Protocol and procedure manual.
- Access to medical records
- Pharmacy logs
- Inventory logs
- Formulary for Pharmaceuticals

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MPR 13

Projects must operate in accordance with federal and state law and guidelines regarding the provision of laboratory services related to family planning and preventive health

Reference: *42 CFR §59.5 (b)(1); 29 CFR 1910.1030; 42 CFR 493.*

Indicator 13.1

Laboratory Testing and Follow-up

See Michigan Title X Family Planning Standards & Guidelines (9.6; 9.7; 17; 19.I; 21.F.1.c, d; 24.A; 26; 28; 28.A.2; 29.E.2. f, g, h)

To fully meet this indicator:

- Written laboratory protocols and procedures must be in place that include: **(9.6; 9.7; 17; 19. J; 21.F; 25.A; 26; 28; 28.A.2)**
  - Pregnancy testing must be provided on site
  - Cervical cancer screening must be provided on site
  - STI and HIV testing, or referral for testing
  - 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)**

Documentation Required:

- Protocol and procedure manual
- Access to medical records
- Appropriate CLIA certificate
- Laboratory logs
- Equipment maintenance logs

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MPR 14

Projects must establish a medical record for all Title X clients who receive clinical services, including pregnancy testing, counseling and emergency contraception. Medical records must comply with Health Insurance Portability & Accountability Act of 1996 (HIPAA) privacy and security standards and document quality care standards.

Reference: *42 CFR §59.5 (b)(1); Health Insurance Portability and Accountability Act of 1996 (HIPAA)*

Indicator 14.1

Medical Records and Quality Assurance System

See Michigan Title X Family Planning Standards & Guidelines (29.D.1.a, b; 29.D.2; 29.E; 29.E.2.d, i)

To fully meet this indicator:

- A medical record is established for all clients who receive a clinical service. **(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
- Medical records contain the following: (**29.D.2)**
  - Personal data sufficient to identify the client:
    - Name
    - Unique medical record number
    - Address
    - Phone/How to contact
    - Age
    - Sex
    - Race & Ethnicity (FPAR requirement)
    - Income assessment
  - Allergies
  - Medical history, as indicated by service(s) provided
  - Physical exam, as indicated by services(s) provided
  - Documentation of clinical findings, diagnostic/therapeutic orders, including:
    - Treatments initiated and special instructions
    - Continuing care, referral and follow-up
    - Scheduled revisits
  - Documentation of all medical encounters, including telephone encounters
  - Documentation of all counseling, education, and social services
  - 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.)**
  - 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)**

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Documentation Required:

- Service protocol and procedure manuals
- Access to medical records
- Documentation of 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 Chart Audits/ Record Monitoring Audits to determine completeness and accuracy of medical records being conducted quarterly by a QA committee member or identified personnel?

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MPR 15

Provide for coordination and use of referrals and linkages with primary healthcare providers and other providers of healthcare services, local health and human service departments, hospitals, voluntary agencies, and health services projects supported by other federal programs.
Provide for social services related to family planning, including counseling, referral to other social and medical services agencies, and ancillary services which may be necessary to facilitate clinic attendance.
Provide that referral services as convenient as feasible to promote access to services.

References: *42 CFR §59.5 (b)(8); 42 CFR §59.5 (b)(2)*

Indicator 15.1

Provide for Coordination of referral arrangements for other health care, related social services and counseling

See Michigan Title X Family Planning Standards & Guidelines (9.5; 9.7; 9.7.A; 17; 19.L; 21.G; 29.A; 29.A.1-6; 29.D.2.c, f)

To fully meet this indicator:

- Projects must provide for referrals to other medical facilities as medically indicated. **(9.5; 17)**
- Provide that referrals and follow-up are provided, as indicated, including: **(19.L; 29.A; 29.A.3,4,5)**
  - 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
- Referral and follow up procedures must be sensitive to client concerns for confidentiality and privacy. **(29.A.1)**
- 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.3a.b.c; 29.D.2.c; 29.E.2.a)**
  - A method to identify clients needing follow up
  - A tracking system to document referrals and follow up procedures
  - A method to track follow-up results on necessary referrals
  - Documentation in the medical record of contact and follow up
    - Documentation of reasons when follow up was not completed
  - Referral procedures must be sensitive to confidentiality and privacy concerns.
- 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: **(9.5; 9.7.A; 29.A.1,5)**
  - 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
  - Referrals are made to providers conveniently located for clients where feasible.
- Social services related to family planning, including counseling services must be provided either on-site or by referral **(9.4; 9.5;9.7; 9.10; 9.11; 17; 19.C,D,E; 21.G; 29.A.6)**
- Counseling must be accurate, balanced, and non-judgmental on the contraceptive methods, STIs and HIV. **(9.11; 21.G)**
- The agency must offer education on HIV and AIDS, risk reduction information and either on-site testing or referral for this service. **(17; 26.G)**
- Counseling and referral services must be in place to address identified intimate partner violence and human trafficking **(9.4.A,B)**

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- 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)**
- Referral lists for social services agencies and medical referral resources must be current and reviewed annually. **(25.E; 29.A.6)**
- The client counseling must be documented in the medical record. **(21.G; 29.D.2.f)**
- Agency must maintain a referral list, updated annually, 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)**

Documentation Required:

- Protocol/procedure for counseling and referring to other health care, local health and human service departments, hospitals, voluntary agencies or health services projects
- Current referral list, updated annually
- Documentation of referrals and follow-up
- Medical records with counseling documentation

Evaluation Questions:

- Are counseling services provided based on the individual client needs/request for services?

Section X: Women, Infants, and Children Administration (WIC)

MPR 1

The WIC Management Evaluation and Corrective Action Plan (as required) are conducted and satisfactorily completed on a biennial basis as mandated by the United States Department of Agriculture.

Reference: *(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 Action Plan (CAP) 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 CAP for each of the indicators must be Met/Completed.

See WIC Schedule for applicable WIC ME, WIC Follow-Up CAP.

Documentation Required:

ME status letter indicates all indicators MET.

Final ME Follow up Review Corrective Action Plan letter shows all indicators MET or complete.

Evaluation Questions:

- Are all WIC ME indicators Met?
- Are all WIC ME CAP indicators met or completed?

To access the Management Evaluation Review Tools, please use this web address:
https://www.michigan.gov/mdhhs/assistance-programs/wic/resources/management-evaluation-tools

For technical assistance, please contact Nancy Erickson at 517-335-9562 or ericksonn@michigan.gov, or Gloria Zunker at 517-275-2601 or zunkerg1@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
<183	.25	.25
183-488	.50	.25-.50
489-732	1.0	.50
733-976	1.0-1.5	1.0
977-1,586	2.0	1.0-1.5
1,587-2,440	2.0-2.5	1.5-2.0
2,441-3,416	3.0	2.0
3,417-4,026	5.0	5.0
>4,206	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 to be submitted only if requested by Reviewers.*
- 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)

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 the CSHCS Annual meeting.

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 Annual 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.
- LHD New Staff Orientation Verification Form of completed required training courses including name and date. *Materials to be submitted only if requested by Reviewers.*

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 CSHCS Annual meeting?

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 or prior to onsite reviews LHD staff will be asked to demonstrate proficiency with the database by showing reviewers how to find one or more of the following pieces of information using the CSHCS database:
    - Client look-up
    - Medical report received date
    - Listing of approved providers
    - Renewal information
        - Financial
        - Medical
    - Where to find MDHHS/CSHCS notes
    - Client in TEP status
    - How to find LHD reports
    - Update client address
    - Where to find prior enrollment periods
    - Where to find letters that have been sent out and date sent
    - Open payment agreements

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?

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Indicator 2.2

The LHD CSHCS program staff shall use the secure electronic method of communication for sharing of PHI designated by CSHCS (e.g. 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.
- During or prior to onsite reviews LHD staff will be asked to demonstrate proficiency with the designated electronic system for sharing PHI by showing reviewers how to find one or more of the following pieces of information:
    - Search Documents
    - View Documents
    - View Messages
    - Send Messages
    - Upload a Document
    - Create a Fax Coversheet
    - County to County Transfer

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 LHD staff able to identify appropriate document types/titles for non-routine document uploads?

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:

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All below are required.

- Physical evidence of comprehensive client records exists. The previous three years' activities in client charts must 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).

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?
- What electronic formats do you use to communicate with families (email, Facebook, text, etc.) and how do you ensure PHI remains secure?

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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.
- On-site interview that demonstrates how LHD CSHCS locations are accessible to clients and/or families (i.e. parking, signage, wheelchair accessible doorways, hours of operation, etc.).

Evaluation Questions:

- Does the LHD CSHCS program have a language line, interpreters, or materials available in other languages?
- Do families often come to the LHD in-person?

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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. LHD CSHCS shall demonstrate awareness of the CSHCS Comprehensive Agreement (CA) and submission timeframes.

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.
- Written policy and procedure delineating how data required for reporting is collected, compiled and submitted in the format and timeframes specified within the CSHCS Comprehensive Agreement.
- On site interview will include having LHD CSHCS staff demonstrate their proficiency with the Guidance Manual and Medicaid Provider Manual by showing 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?
- Are LHD staff able to locate specific information regarding non-routine situations within the Guidance Manual or 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:

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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.

Documentation Required:

All below are required.

- Written policies and procedures with dated notation of annual review and revisions as necessary. *Materials must be submitted in advance of the review.*

Evaluation Question:

- Are CSHCS program staff involved in updating procedures annually?

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:

All below are required.

- Written policy and procedure delineating how and when family input is obtained.
- Copies of input from families e.g., family survey documents and results, pre/post event surveys, focus groups, 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:

- How many methods have you utilized to gather family input and how could it be improved?
- Are survey results discussed in staff meetings and how was the input utilized and/or incorporated to enhance the program?

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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 three 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.
- Written policy and procedure delineating how/when diagnostic evaluations are issued and documented.

Example of further documentation to meet the requirement, including but not limited to:

- Log sheet summarizing outreach efforts. *Materials should be submitted in advance of the review.*
- 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.*
- 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.*
- Electronic forms of outreach (e.g., Facebook, LHD website, etc.).

Evaluation Question:

- Does the LHD allow CSHCS program staff the opportunity to attend outreach events?

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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, CMH, MRS, MIChild, Healthy Kids, Medicaid, HCC/TEFRA, SSI and Medicare.

Documentation Required:

(The first two bullets are required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating referral process including information about available community resources for LHD clients with special health needs but not enrolled in CSHCS.
- 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 individual plan of care.
- Client IEPs/504s, MiAble account applications, Project Search applications, etc.
- 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 track assistance to CYSHCN not on the CSHCS program?

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:

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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 (i.e. Family center one-pager)
- Family correspondence
- Welcome packet
- Information included on the LHD CSHCS website and other social media platforms
- On-site interview that indicates when and how families receive information and referral to the Family Center
- Family Center receiving referrals
- Clients/Families applying for camp and conference scholarships

Evaluation Questions:

- Can LHD CSHCS program staff share additional examples of how Family Center resources were provided or explained to families?
- Does the LHD CSHCS program inform all families about the Family Phone Line and Family Center as appropriate via the Family Phone Line toll-free number, CSHCS website and/or written correspondence and documents developed for families?

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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 and renewal 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 and renewal process and/or forms.

Documentation Required:

(The first two bullets are 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.
- Written policy and procedure delineating the process for which staff attempt to locate families prior to the lapse of CSHCS coverage to offer renewal assistance.

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 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.
- Use of Renewal Follow up report and/or Clients Not Renewed report.
- Documentation to demonstrate attempts to locate families prior to the lapse of CSHCS coverage to offer renewal assistance.

Evaluation Question:

- Is the LHD CSHCS program staff able to assist families with IRPA amendments?

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Indicator 5.2

LHD CSHCS shall locate individuals or families who do not return a CSHCS Application within 30 days after being invited to join CSHCS, to offer assistance with application completion.

This indicator may be met by:

The LHD CSHCS program shall have evidence of attempting to locate those who have not returned an application within 30 days of being invited to join CSHCS and of offering to assist with completing the application.

Documentation Required:

(The first bullet is required as written. Other documentation is needed to complete the requirement.)

- Written policy and procedure delineating the manner in which families who have not returned the CSHCS application within 30 days of invite, are located, how the ones who are located are contacted, the number of attempts to be made when contacting families, the process by which assistance is offered, and how these attempted contacts and successful contacts are to be documented.

Examples of further documentation to meet the requirement, including but not limited to:

- Use of Enrollment Application Not Returned Report
- Evidence of diverse follow-up activities indicating multiple attempts to contact.
- On-site interview that indicates how attempts are made to locate families who have not returned the CSHCS application and how assistance is offered.

Evaluation Questions:

- Does the LHD CSHCS program offer assistance with application completion to the families that have been located?
- Does the client record show diverse contact attempts?

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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 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.
- Evidence of diverse contacts with 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?
- Does the client record show diverse contact attempts?

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, rights and responsibilities 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:

All bullets are required as written.

- 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.
- Written policy and procedure delineating the process for which staff inform families of their Rights and Responsibilities under CSHCS.
- 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.

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.
- 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 Welcome Packet and Annual Update packet shared with families.

Evaluation Questions:

- How does the LHD assess client/family needs annually?

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Indicator 6.2

LHD CSHCS shall assist the CSHCS enrolled client/family with needs related to CSHCS care and services as appropriate. Examples include: adding authorized providers, billing problems, hospice, insurance issues, premium assistance, application to the CSN fund, applications for home care and/or respite 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 services and systems of care navigation.

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:

- Are care and service needs regularly documented as goals if there is a POC in place?

Indicator 6.3

LHD CSHCS program shall facilitate transition for CSHCS enrolled youth, young adults, and their families. 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 of the transition process by the age of 14 or earlier as appropriate.

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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, or Transition Checklist for LHDs.
- 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.

Evaluation Questions:

- How does the LHD assist clients and their families with preparing youth for the transition to adult life?
- Does the LHD CSHCS program assist with transition at transition periods earlier than age 14?
- Can the LHD provide examples of outcomes related to transition?

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 staff assists and, if appropriate, authorizes in-state travel following CSHCS published Non-Emergency Medical Transportation and Assistance (NEMT) policy. There shall be evidence that the LHD CSHCS staff discuss the process to obtain out-of-state travel if the family requests out-of-state assistance.

Documentation Required:

All bullets are required as written.

- 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 guidance.
- Dated client chart notation documenting the client has received in-state transportation assistance and staff identifier.

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- 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 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 NEMT Authorization Addendum 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?

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:

- Evidence the LHD using the Out of State Approvals Report to identify those who may need assistance.
- 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?

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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:

All bullets are required as written.

- Written policy and procedure delineating how Level I and Level II care coordination services are provided to clients/families when needed.
- Written policy and procedure delineating how case management services are made available to clients/families when needed.
- Dated client chart notation documenting the client has received Level I or Level II care coordination services or case management services and staff identifier.
- Plan of Care developed by a registered nurse or licensed social worker, including all essential elements.
- Dated, appropriate, client-specific billing indicating Level I and/or Level II care coordination or case management.

Evaluation Questions:

- Does the LHD make case management available to clients/families appropriately?
- Are care plans individualized and updated accordingly for each client and do they contain all the required elements?

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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. Data required for reporting is collected, compiled and submitted in the format and timeframes specified within the CPBC CSHCS agreement. (Indicator 3.1)
8. LHD CSHCS staff obtain family input on local CSHCS operations on a regular basis. (Indicator 3.3)
9. LHD CSHCS provide outreach to families and the community regarding CSHCS. (Indicator 4.1)
10. LHD CSHCS staff disseminate and provide outreach materials to families and communities. (Indicator 4.1)
11. LHD CSHCS staff authorize diagnostic evaluations for potentially eligible clients. (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 inform and refer families to the Family Center. (Indicator 4.3)
15. LHD CSHCS staff assist families with application to CSHCS or other forms as requested. (Indicator 5.1)
16. LHD CSHCS staff attempt to locate families prior to the lapse of CSHCS coverage to offer renewal assistance. (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 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)
20. LHD CSHCS staff contact families at least annually to update information and remind them of program benefits. (Indicator 6.1)
21. LHD CSHCS inform families of their Rights and Responsibilities under CSHCS. (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 within state and out-of-state. (Indicator 6.4)
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)