

Michigan Local Public Health Accreditation Program

Cycle 9

Local Health Departments – User's Guide



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Michigan Local Public Health Accreditation Program Reviewer User's Guide

1- Introduction

Developed in direct consultation with the Program's participants, this User's Guide is intended to systematically outline, clarify, and explain all relevant policies, procedures, and processes integral to successful participation in the Accreditation Program.

This document is part of a continuous quality improvement process. It is fluid and fully expected to change as local public health departments provide input that contributes to its usefulness. To provide input or ask questions, please contact one of the individuals below.

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Michigan Local Public Health Accreditation Program Reviewer User's Guide

2- Overview

2.1 History

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

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

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

2.2 Governance

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

- Michigan Department of Health and Human Services (MDHHS)
- Michigan Department of Agriculture and Rural Development (MDARD)
- Michigan Department of Environment, Great Lakes, and Energy (EGLE)

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

2.3 Standards

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

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



Michigan Local Public Health Accreditation Program Reviewer User's Guide

2.4 Process

The Accreditation Program assesses the ability of an LHD to meet minimum administrative capacity requirements. The Accreditation Program also conducts LHD performance reviews for contractual local public health operations services and certain categorical grant funded services LHDs provide.

There are three steps to the Accreditation process:

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

The review process requires a team of approximately 70 state agency Reviewers, of which about 20 are used for each On-Site Review. The review cycle is 3 years. Following the On-Site Review and CPA processes, there are three Accreditation status options. These are:

- Accredited
- Accredited with Commendation
- Not Accredited

2.5 Evaluation

MPHI conducts ongoing evaluation of the Michigan Local Public Health Accreditation Program and its components throughout each 3-year cycle by regularly reviewing available data and providing data and recommendations to the Accreditation Commission. Evaluation results and data are used to improve the quality of the program.

2.6 Conclusion

The work that has been undertaken in Michigan to achieve the goals of building capacity and developing infrastructure began with the creation of the Public Health Code (Public Act 368 of 1978, as amended), specifically Section 24, which begins to define the role of LHDs in Michigan. Without this framework, Michigan would have been challenged to establish an Accreditation Program with the depth and breadth present today. Continued commitment and collaboration by the MDHHS, MDARD, EGLE, MPHI, Michigan's 45 LHDs, and the Michigan Association for Local Public Health (MALPH) will enhance Michigan's Accreditation Program, improve the quality of local programs and services, and shape the future of public health in Michigan.

The Michigan Local Public Health Accreditation Program website is available for LHD staff and Reviewers. The website provides a wealth of information about the Michigan Accreditation process and includes supporting resources such as Users' Guides, MPR Indicator Guide (for all or individual programs), and links to Quality Improvement resources and the Accreditation Web Module. To visit the site, use the following link: <https://Accreditation.localhealth.net/>

3- The Michigan Local Public Health Accreditation Process





4- Self-Assessment

4.1 What to Expect

The Self-Assessment is the first step in the Accreditation process. An LHD completes the self-assessment, which serves as an internal review of the department's ability to meet the minimum program requirements. The Self-Assessment phase begins four (4) months before the On-Site Review, when MPHI sends the LHD's Health Officer (and Accreditation Coordinator, if applicable) an email with a link to the Cycle 9 Accreditation Tool. The email also highlights pertinent dates in the process as they apply to each LHD.

The Tool is located on the [Michigan Local Public Health Accreditation Program website \(https://Accreditation.localhealth.net/\)](https://Accreditation.localhealth.net/) and is available to anyone at any time at that link.

The Self-Assessment should be completed using the MPR Indicator Guide for each section on which the LHD will be reviewed. The MPR Indicator Guide also presents detailed information on the documentation an LHD provides in order to fully meet the Indicators during a normal Accreditation Cycle.

4.2 Pre-Materials to MPHI

To facilitate the flow of information between the LHD and MPHI during all phases of the Accreditation process, the LHD should appoint an Accreditation Coordinator and identify that person to MPHI on the **Profile Information area of the Accreditation Web Module and/or on the Module User Account Request form**. The Module User Account Request form is submitted to the MPHI Program Assistant via email at least two weeks prior to the pre-materials due date. Unless otherwise notified, MPHI will consider this person the single point of contact during the process.

There are several important pieces each LHD needs to complete and deliver to MPHI to officially complete the Self-Assessment phase. All materials will be submitted via the [Accreditation Web Module \(https://webreport.Accreditation.localhealth.net/\)](https://webreport.Accreditation.localhealth.net/). These pre-materials (Profile Information, Exit Conference information, and the On-Site Review Schedule) are due to MPHI 2 months prior to the On-Site Review. For more information about submitting pre-materials and step-by-step instructions in Section 5 - [Navigating the Accreditation Web Module](#).

The LHD will create the schedule for the 5-day On-Site Review while adhering to the Scheduling Guidelines provided in [Appendix I](#). It is understood that staff members will often be responsible for multiple programs. This and other factors should be taken into consideration as the schedule is being prepared. MPHI and the Accreditation Reviewers will receive the LHD's schedule as final. In the event that either a Reviewer or the LHD needs to make changes to this schedule after it is submitted to MPHI due to extenuating circumstances or unforeseen events, it is critical that MPHI be contacted as soon as it is evident that a change to the schedule is needed. The Reviewer and LHD should work together to find a mutually acceptable new date within one week before or after the scheduled On-Site Review week to complete the review, then contact MPHI staff to inform them of the new date. Upon submission, MPHI will review and publish the schedule for LHD staff and Reviewers to see.



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

If an LHD needs to reschedule its On-Site Review, they must request a scheduling change, in writing, at least three months prior to the start of the scheduled Self-Assessment period. The request must be e-mailed to MPH and include the rationale for the schedule change. MPH will collaborate with MDHHS, MDARD, EGLE, and the MLPHP Accreditation Commission regarding the feasibility of accommodating the request. All parties will be notified of the outcome.

4.3 Requested Program Pre-materials

Some services/programs administered by an LHD require separate pre-materials; the table below outlines the programs that have separate pre-materials and where to find additional information related to those.

Program	Where to find pre-material information
Powers and Duties – Plan of Organization	Link to Document
Powers and Duties – Quality Improvement Supplement	Appendix II
General Communicable Disease	Appendix III
HIV/AIDS & STI	Appendix IV
HIV/AIDS & STI *Optional Program Companion Guide	Link to Document
Family Planning	Appendix V
CSHCS	Appendix VI

4.4 Technical Assistance Contacts

LHDs should contact relevant state agency staff in the event that clarification is needed regarding minimum program requirements and/or Indicators. [Appendix VII](#) has a list of state agency Technical Assistance Contacts that includes names, email addresses, and phone numbers.

4.5 Tips to Facilitate the Process

- Be certain to allow enough time for the Self-Assessment phase by beginning upon receipt of your Accreditation Tool, 4 months before your On-Site Review week.
- Assemble a management team comprising the Health Officer, Medical Director, Finance Director, Personal Health Services Director, and the Environmental Health Director (or equivalents). Remember to include the designated Accreditation Coordinator if not already identified above. Regular meetings for progress reports are beneficial.
- Keep all staff and other relevant entities informed about the Accreditation process, including the local governing entity (Board of Health, County Commission, etc.).
- Fresh eyes looking at programs in the LHD can often make a positive impact in preparation. Utilize and involve your staff by having them review programs other than their own. For example, the



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immunization staff could review the food service sanitation program; the food service sanitation program could review the immunization program and so on.

5- Navigating the Accreditation Web Module

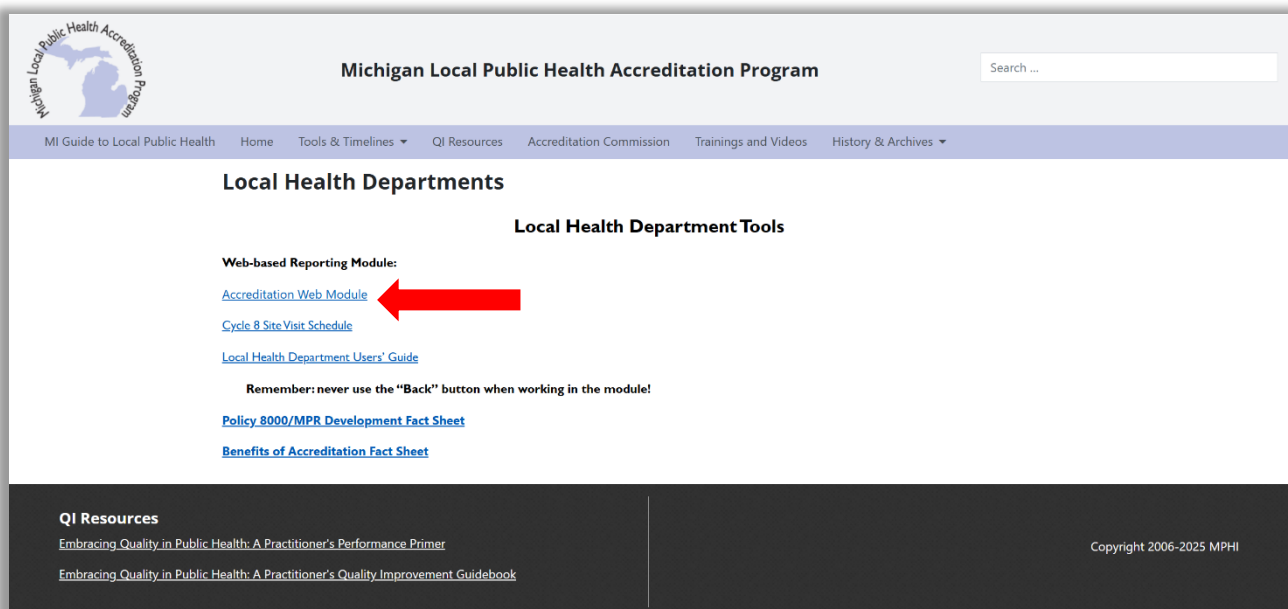
Open your Internet browser and follow this link by holding the Ctrl Key and clicking this underlined link: <https://Accreditation.localhealth.net/> or by copying it into the address bar of the browser.

On the Home screen, click the “Local Health Departments” picture.



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

On the Local Health Department Tools page, click the “Accreditation Web Module” link.

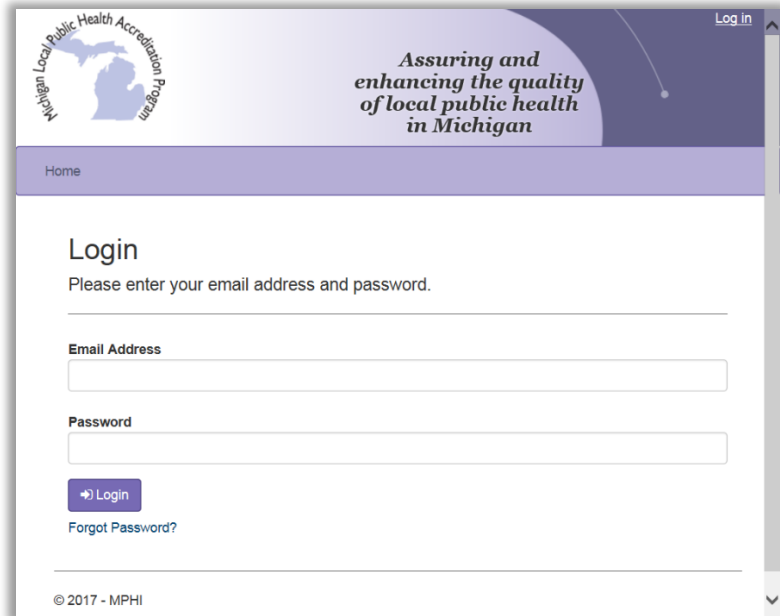


5.1 Logging into the Accreditation Web Module

A form to request Accreditation Web Module user accounts is sent with your LHD's Tool letter.

Please submit this form by email to Jessica Nash jnash@mphi.org **no later than 2 weeks prior to your pre-materials due date.** MPHI will create user accounts for each person listed on the form when it is submitted. The first time a new user logs in to the Accreditation Web Module they will be required to set a password.

Health Officers' accounts have special permissions that allow them to see all reports for the health department and provide signoffs on materials as needed. All other accounts will have standard LHD access to the Accreditation Web Module.



The screenshot shows the login page of the Accreditation Web Module. At the top left is the Michigan Local Public Health Accreditation Program logo. To the right of the logo is the text "Assuring and enhancing the quality of local public health in Michigan". Below this is a "Home" link. The main heading is "Login" with the instruction "Please enter your email address and password." There are two input fields: "Email Address" and "Password". Below the password field is a "Login" button with a right-pointing arrow. A "Forgot Password?" link is located below the login button. At the bottom left of the page is the copyright notice "© 2017 - MPHI".

Important!

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

5.2 Changing Your Password

Forgot Password

When a user has forgotten their account password, the user can reset it on the Forgot Password page. Users can access the Forgot Password page by selecting the “Forgot Password?” link on the Login page. A user can complete the Forgot Password process by following the steps listed below:

Step 1: Select the “Forgot Password?” link on the Login page

Step 2: Enter the email address associated to your account in the “Email Address” field

Step 3: Select the “Email Link” button to send yourself a reset password email

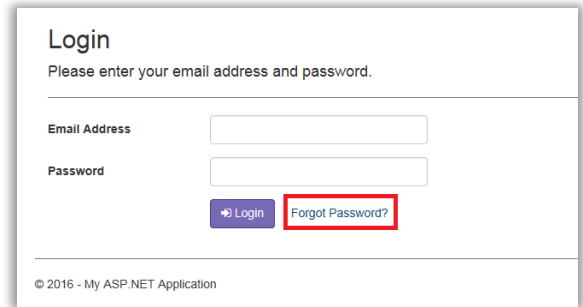
Step 4: Follow the URL provided in the email

Step 5: Enter your new password in both the “Password” and “Confirm Password” fields. The new password must be different than your current password, be a minimum of 8 characters, and include:

- An uppercase letter
- A lowercase letter
- A number
- A symbol

Step 6: Select the “Set Password” button

Note: A user's password will expire every 120 days. Upon login, a user with an expired password will be prompted to create a new one.



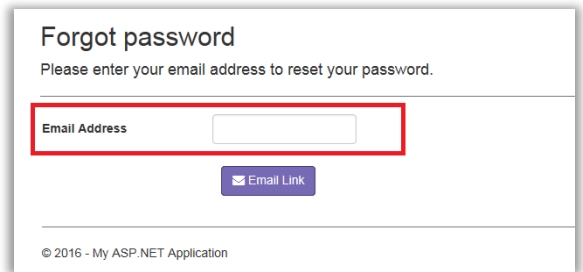
Login
Please enter your email address and password.

Email Address

Password

[Login](#) [Forgot Password?](#)

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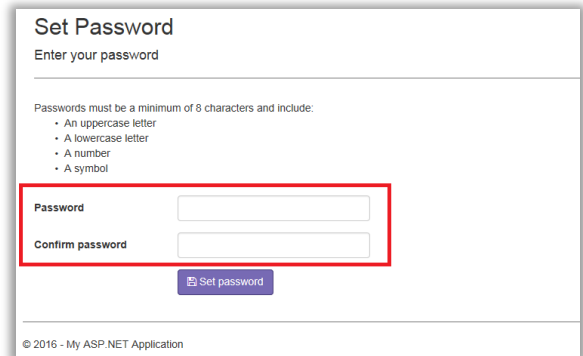


Forgot password
Please enter your email address to reset your password.

Email Address

[Email Link](#)

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Set Password
Enter your password

Passwords must be a minimum of 8 characters and include:

- An uppercase letter
- A lowercase letter
- A number
- A symbol

Password

Confirm password

[Set password](#)

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Change Password

When a user would like to change their account password, the user can do so on the Change Password page by following the steps listed below:

Step 1: Select the “Change Password” link on the Home page

Step 2: Enter your current password in the “Current Password” field

Step 3: Enter your new password in both the “New Password” and “Confirm New Password” fields. The new password must be different than your current password, be a minimum of 8 characters, and include:

- An uppercase letter
- A lowercase letter
- A number
- A symbol

Step 4: Select the “Change Password” button

Note: A user's password will expire every 120 days. Upon login, a user with an expired password will be prompted to create a new one.

The screenshot shows a user interface titled "Activities". Underneath, there is a section for "Health Department Information" with links for "Profile" and "Review Schedule". At the bottom of this section, a button labeled "Change Password" is highlighted with a red rectangular box.

The screenshot shows the "Change Password" form. It includes a heading "Change Password" and a list of password requirements: "Passwords must be a minimum of 8 characters and include: An uppercase letter, A lowercase letter, A number, A symbol". Below this, there are three input fields: "Current password", "New password", and "Confirm new password". The "Current password" field is highlighted with a red rectangular box. At the bottom right, there are two buttons: "Change Password" and "Cancel". A footer at the bottom reads "© 2016 - My ASP.NET Application".

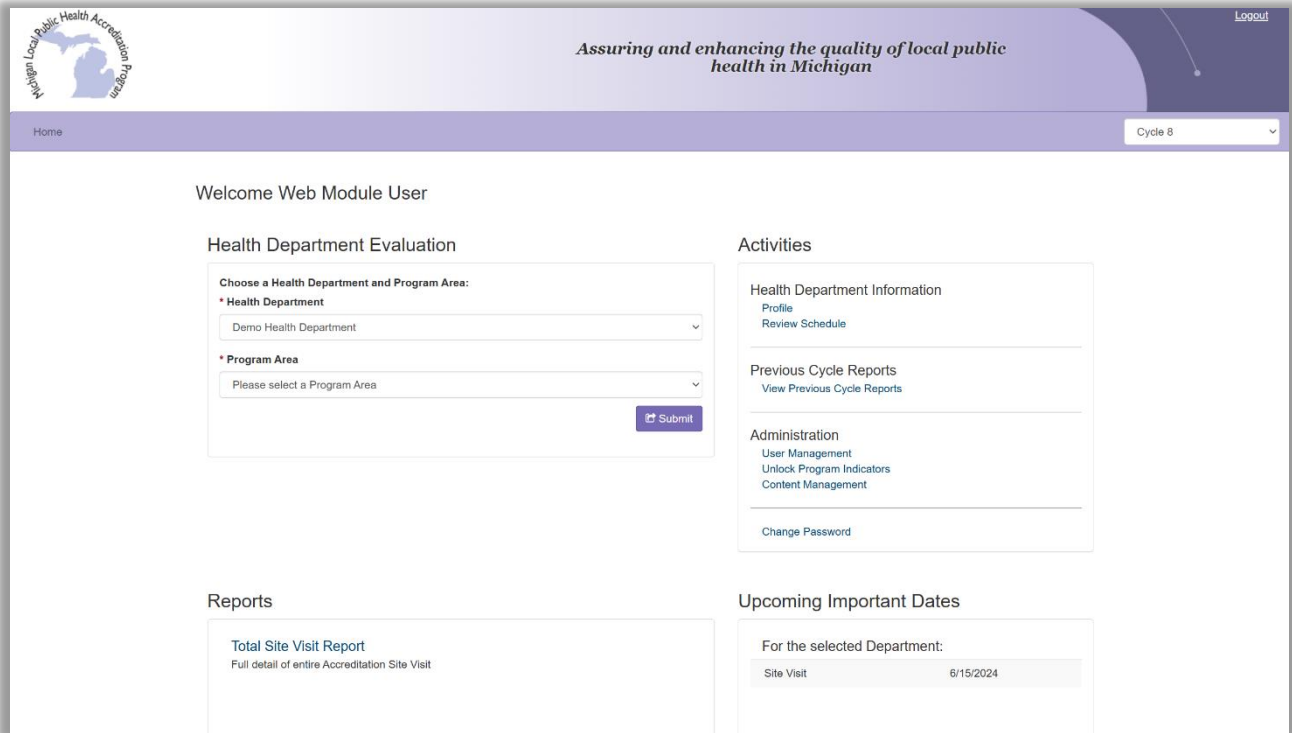
This screenshot is identical to the previous one, showing the "Change Password" form. In this version, the "Change Password" button at the bottom right is highlighted with a red rectangular box. The footer at the bottom reads "© 2016 - My ASP.NET Application".



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5.3 Home Page

The Home page is the default landing page for users when they first log into the Accreditation Web Module. There are 4 sections on the Home page: Health Department Evaluation, Activities, Reports, and Upcoming Important Dates.



5.4 Submitting Pre-materials in the Accreditation Web Module

All LHD pre-materials are submitted via the Accreditation Web Module, including the On-Site Review Schedule, Exit Conference requests, and updating the LHD's profile. Some programs require materials to be sent in advance of the On-Site Review. Please see [Appendix II – VI](#) for further information.

Review Schedule

To enter your schedule, click the “Review Schedule” under the Activities menu on the Accreditation Web Module Home page. You will be taken to a screen that looks like this:



Michigan Local Public Health Accreditation Program Tool Local Health Department User's Guide

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

Demo Health Department
On-site Review Week of: 2/16/2026
Reports: [On-site Review Schedule Report](#)
[Complete Pre-materials Report](#)

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

Schedule Programs

Program Area

Please select a Program Area ▼

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM
<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM

Schedule Outside of Scheduled Review Week

Date AM PM

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

Quality Improvement Supplement (QIS) selection updated ×

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

Demo Health Department
On-site Review Week of: 2/16/2026
Reports: [On-site Review Schedule Report](#)
[Complete Pre-materials Report](#)

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

To schedule a program, scroll down on the Review Schedule page. Below the “Submit” button, you will see a table outlining each of the Accreditation programs. Each program has already been added for your LHD and should list the Reviewer(s) who will be conducting your On-Site Reviews for each program area. Your LHD will need to add in the dates and times of the reviews, as well as the LHD staff that will be participating in each review. This will also be the place to indicate if your LHD would like Reviewers to conduct an Exit Conference, and who needs to be in attendance.



Michigan Local Public Health Accreditation Program Tool Local Health Department User's Guide

To add the date and time for a program's review, scroll down to the program you wish to update and click the "Edit" button.

Program Area	Scheduled	Actions
Powers and Duties		Edit Delete Add Reviewer Add LHD staff Add exit attendee
	Reviewer Name	Phone Email Actions
	State Reviewer	sreview@test.com Remove
Food Service		Edit Delete Add Reviewer Add LHD staff Add exit attendee
	Reviewer Name	Phone Email Actions
	State Reviewer	sreview@test.com Remove
General Communicable Disease Control		Edit Delete Add Reviewer Add LHD staff Add exit attendee
	Reviewer Name	Phone Email Actions
	State Reviewer	sreview@test.com Remove

This will allow you to select the date and time of the On-Site Review during your scheduled Accreditation review week by checking the appropriate boxes (e.g., Monday AM, Friday PM, etc.). Refer to [Appendix 1](#) for scheduling guidance.

Schedule Programs

Program Area

Powers and Duties

Monday	Tuesday	Wednesday	Thursday	Friday
<input checked="" type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM
<input checked="" type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM

Schedule Outside of Scheduled Review Week

Date AM PM

If you and your Reviewer(s) cannot meet during the scheduled review week, you are allowed to schedule the On-Site Review within the week prior or week after the scheduled Accreditation review week. To do so, check the box next to "Schedule Outside of Scheduled Review Week" and select the date of the Review.

Schedule Programs

Program Area

Powers and Duties

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM	<input type="checkbox"/> AM
<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM	<input type="checkbox"/> PM

Schedule Outside of Scheduled Review Week

Date: AM PM

June 2026

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

After you have made your selections, click the "Submit" button and the updates will be added to the schedule. Next, click the "Add LHD staff" to input the information of staff who will be involved in the review process.

Program Area	Scheduled	Actions								
Powers and Duties		Edit Delete Add Reviewer Add LHD staff Add exit attendee								
	<table border="1"> <thead> <tr> <th>Reviewer Name</th> <th>Phone</th> <th>Email</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td>State Reviewer</td> <td></td> <td>sreview@test.com</td> <td>Remove</td> </tr> </tbody> </table>	Reviewer Name	Phone	Email	Actions	State Reviewer		sreview@test.com	Remove	
Reviewer Name	Phone	Email	Actions							
State Reviewer		sreview@test.com	Remove							

Add LHD Staff

Which LHD staff will be involved in the review?

Name:

Title:

Email Address:

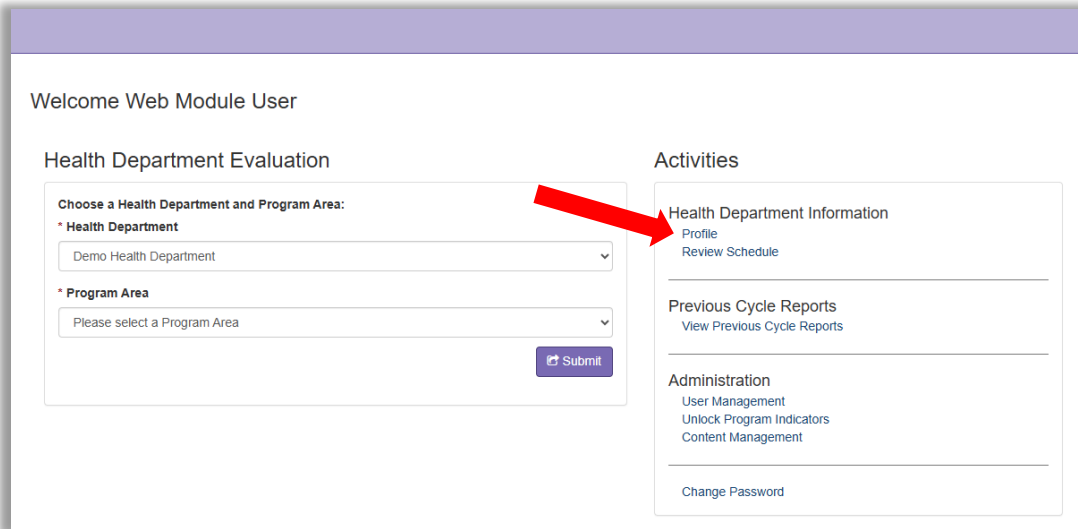
Phone Number:



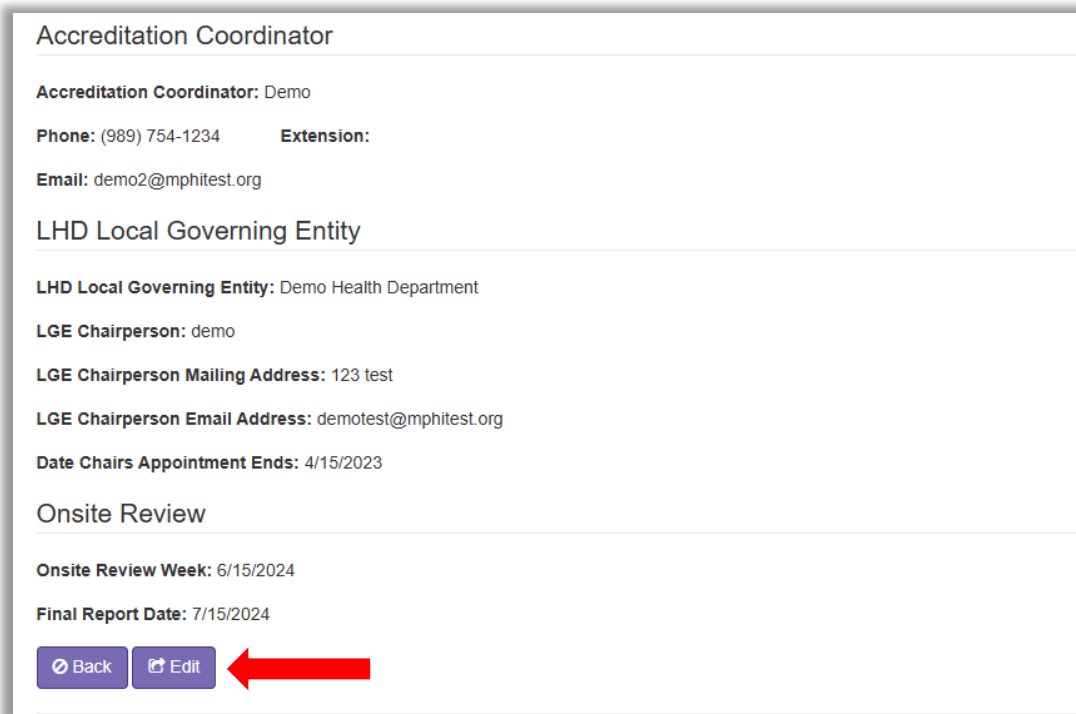
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Update Your Local Health Department's Contact Information

To edit your LHD's contact information, click the "Profile" link on the Home page.



On the bottom of the Local Health Department Contact Information page, click the "Edit" button.





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Clicking the “Edit” button will allow you to complete and update any information about your health department.

Local Health Department Contact Information – This section includes the LHD’s name, address, phone number, and website.

Health Officer – The Health Officer section includes the LHD Health Officer’s name, phone number, and email address.

Local Health Department Contact Information

LHD Name:

Street Address:

Mailing Address (if different):

City:

State:

Zip:

Phone:

Extension:

LHD Website (if applicable):

Health Officer

Health Officer:

Phone:

Extension:

Email:



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Accreditation Coordinator – The Accreditation Coordinator section includes the LHD Accreditation Coordinator's name, phone number, and email address.

LHD Local Governing Entity – This section includes the LHD local governing entity's (LGE) name, the name of the LGE's Chairperson, when the Chairperson's appointment ends, and the Chairperson's mailing and email addresses.

Accreditation Coordinator

Accreditation Coordinator:

Phone: Extension:

Email:

LHD Local Governing Entity

LHD Local Governing Entity:

LGE Chairperson:

LGE Chairperson Mailing Address:

LGE Chairperson Email Address:

Date Chairs Appointment Ends:

Onsite Review

Onsite Review Week:

1 Year Post-Review Deadline:

Final Report Date:

On-Site Review – The On-Site Review section lists important dates for the selected LHD. The date in the Onsite Review Week field indicates the first day of the week that the LHD's On-Site Review will take place. The date in the 1 Year Post-Review Deadline for CPA Implementation field indicates the final date by which all CPAs must be implemented to be considered for Accreditation. The Final Report Date field indicates when the final report will be available for the LHD.

Once you have entered your LHD's current contact information, click the "Update Profile" button.

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



Completed Pre-material Reports

Once you have finished entering your pre-materials, MPHI staff will review them for accuracy of scheduling and contact you with any questions. You will receive an automatic email when pre-materials are published.

To view the completed pre-materials, click the "Review Schedule" link on the Home page. On the Review Schedule page, click the "Complete Pre-materials Report" link to view a PDF of your health department's pre-materials. If you wish to access a PDF of the schedule only, click the "On-Site Review Schedule Report" link.

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

Demo Health Department
On-site Review Week of: 6/15/2024
Reports: [On-site Review Schedule Report](#)
[Complete Pre-materials Report](#)

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

5.5 Uploading Documents in the Web Module

Some programs request that documents be submitted ahead of the On-Site Review via the Accreditation web module. **Please note:** files containing Personal Health Information (PHI) or other such confidential information should not be uploaded to the Accreditation Web Module.

To do so, on the homepage select the Program Area you wish to upload documents for by utilizing the dropdown box. Once you have selected the desired Program Area, click the "Submit" button.

Health Department Evaluation

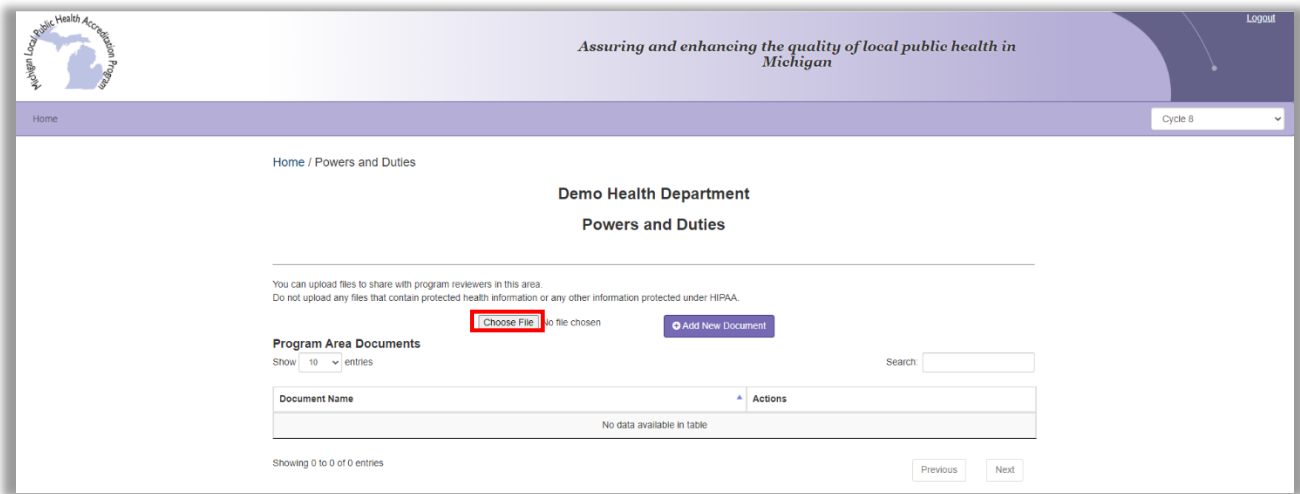
Choose a Health Department and Program Area:

* Health Department
Demo Health Department

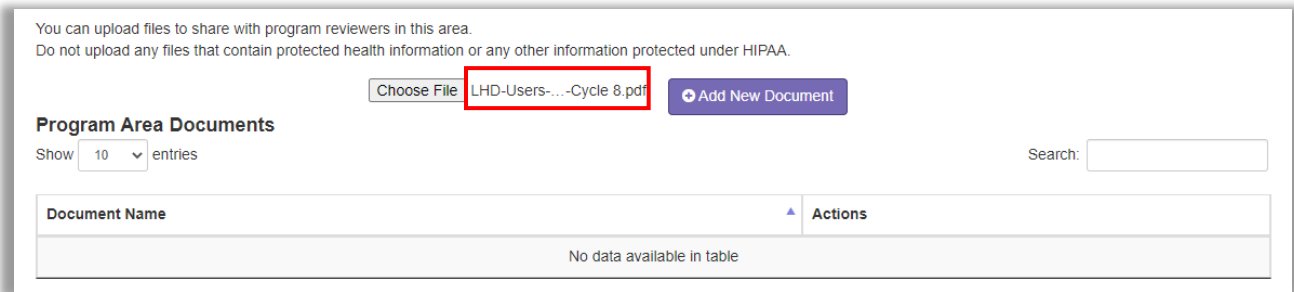
* Program Area
Powers and Duties

Submit

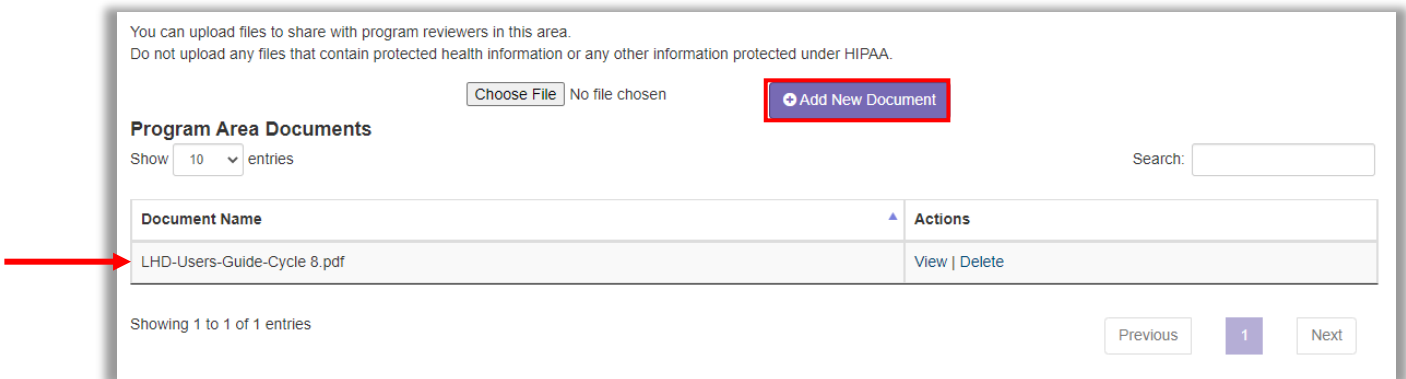
This will take you to the Program Area page. From here you will select the “Choose File” button, which will bring up your computer's files.



Select the document you wish to upload from your files and click “Open”. The name of the selected file should appear next to the Choose File button.



Select the “Add New Document” button to upload your file for Reviewers to access. The document will show up below in the documents table.



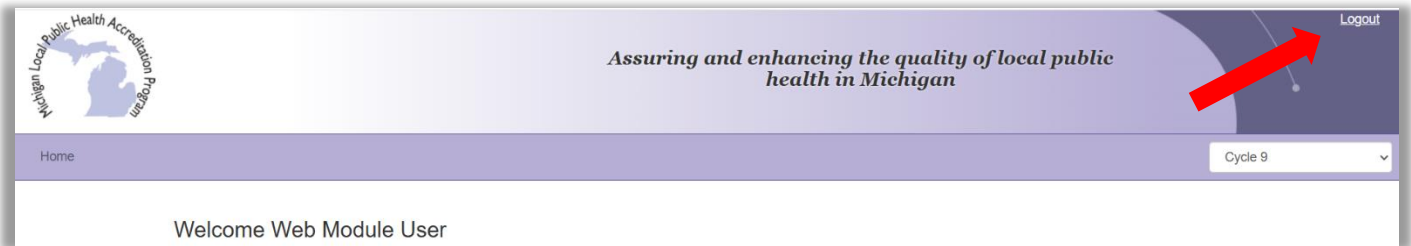
Repeat this process as necessary to add additional documents.



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5.6 Exiting the Accreditation Web Module

Important! A “Log Out” hyperlink is located at the bottom of the main LHD home page. Please use this hyperlink to exit the Accreditation Web Module before closing your Internet browser to ensure you are fully logged out of the system. When you simply close your Internet browser, the website cannot detect this type of exit and thinks that you are still logged into the Web Module.



6- On-Site Review

6.1 What to Expect

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

6.2 Suggestions

- Spend your Self-Assessment period (and beyond) asking questions – reach out to state agency Reviewers and/or Technical Assistance Contacts, or MPH. The more your LHD knows about the entire process, the better your On-Site Review experience.
- Providing food and/or beverages for Reviewers during the On-Site Review is neither mandatory nor expected.
- Ensure the Reviewers meet with the LHD staff identified on the schedule. If the scheduled staff member becomes unavailable at the last moment, let either the Reviewer or MPH know.
- Opening sessions on the first day of the week are not mandatory. Upon state agency Reviewer arrival, engage them in dialogue that will determine logistics during the On-Site Review, such as if LHD staff will be needed, what documentation may be required, etc.



6.3 Exit Conferences

If the LHD would like assistance in facilitating opportunities for program-specific Exit Conferences with state agency Reviewers, the following should be submitted with the other pre-materials using the Accreditation Web Module:

1. Identify Accreditation sections for which an Exit Conference is requested, and
2. Identify, by name, LHD representatives to be included in the conference (e.g., Health Officer, Program Director, etc.). LHD preferences will be communicated to state agency Reviewers before the On-Site Review.

6.4 The On-Site Review Report

Within 30 days from the last day of the week-long review, notification of the On-Site Review Report's completion and access instructions are sent to the LHD (the Health Officer and/or the Accreditation Coordinator).

6.5 Indicator Designations

Four designations may be utilized by Reviewers in evaluating Indicators of the Minimum Program Requirements (MPRs) for a given section:

- Met
- Not Met
- Met with Conditions
- Not Applicable

Met Designation

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

Not Met Designation

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

Once the LHD enters their CPA into the Accreditation Web Module, and the Reviewer has evaluated the submitted information, the LHD will be notified if the plan of action is:

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



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If further action is required, the type of action required will be dependent on the section and state agency involved, and will be communicated to that LHD. (The state agency may conduct a follow-up review to verify implementation of the plan.) More information on the CPA process can be found in [Section 8 – Corrective Plan of Action](#).

Met with Condition Designation

Each program has the option of awarding a “Met with Conditions” designation for an Indicator reviewed during the Accreditation process. This designation serves as an alternative to giving a “Not Met” when a minor, non-critical deviation is discovered in a review that does not warrant the preparation of a formal CPA. An explanation for the decision to mark an Indicator “Met with Conditions”, will be included under the heading “Met with Conditions” on the Accreditation On-Site Review Report.

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

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

Due to different factors including variation among the sections, state agencies conducting the Reviews, and varying program requirements, it is the responsibility of each program to clearly describe in their guidance document the criteria that will be used for designating an Indicator “Met with Conditions”. For Cycle 9, this guidance was provided to MPHl by all programs in summer 2025.

Not Applicable Designation

The “Not Applicable” status is used when an Indicator is not applicable to a LHD, e.g., they do not participate in a component of the program being reviewed.

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

6.6 Program Specific Met with Conditions Language

Powers & Duties

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



Food Service

A “Met with Conditions” may be granted if the department overall meets the minimum program requirements, but occasional deviations indicate the potential of the requirement not to be met. Based on the requirements specified in the guidance document, a Met with Conditions may be given with the understanding that this MPR will be required to be met at the next scheduled evaluation. Failure to meet this Indicator would result in a “Not Met”.

General Communicable Disease Control

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

Hearing & Vision

A designation of “Met with Conditions” for an Indicator within the Hearing and Vision Screening Programs may be used at the discretion of the Reviewer in cases where minor deviations that can be immediately addressed exist. This will be discussed at the Exit Conference and the Local Health Department agrees that their current protocol may be changed immediately to reflect the written Indicator. The change in protocol will be confirmed at the next Accreditation On-Site Review.

Immunization

A designation of “Met with Conditions” for an Indicator within the Immunization Section may be used at the discretion of a joint consensus between the Technical Manager, the Accreditation Lead and the Reviewer in cases where minor deviations exist. All of the Indicators under the individual Minimum Program Requirements in the Immunization Accreditation tool are associated with program requirements outlined in the Omnibus Reconciliation Act of 1993, section 1928 and Part IV-Immunizations, Sec. 13631, as well as requirements in the most current Vaccines for Children (VFC) Operations Guide; Current Immunization Program Operations Manual (IPOM) and Michigan’s current Resource Guide for VFC Providers.

When multiple components are needed to fulfill an Indicator and the components have not all been met, the Indicator may be marked as “Met with Conditions” provided that the deviation is determined to be a non-critical issue (i.e., will not affect daily operations, investigations, reporting of the local health department, or does not violate state law). When a “Met with Conditions” mark is being considered, it will be discussed with the Reviewer, the Accreditation Lead, and the Technical Manager prior to making this determination.



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Indicators must be met in order for the program to be in compliance with the State and Federal program requirements. Because some Indicators require that report submissions are documented on designated dates, it is difficult to base compliance on a 90 consecutive days timeframe. In those cases, a "Met with Conditions" mark would apply until the next date for compliance arrives. At this point the LHD is expected to submit timely reports, or the Indicator will result in a "Not Met".

Onsite Wastewater Treatment Management

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

HIV/AIDS & STI

A designation of "Met with Conditions" for an Indicator within the HIV/AIDS & STI programs will be used at the discretion of the Accreditation Reviewer on site and based upon the significance of the deviation.

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

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

Family Planning

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



Women, Infants, And Children (WIC)

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

Children's Special Health Care Services (CSHCS)

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

7- Reports

The Accreditation Web Module generates several reports following the On-Site Review. To access these reports, log in to the Accreditation Web Module and look under the Reports section.

7.1 On-Site Review Report

The On-Site Review Report shows the number of Indicators that were Met, Not Met, and Not Applicable, broken down by Program Area.

7.2 Total On-Site Review Report

Similar to the On-Site Review Report, the Total On-Site Review Report shows the number of Indicators that were Met, Not Met, and Not Applicable, broken down by Program Area, for the selected Health Department. The Total On-Site Review Report also contains the Health Department Evaluation details, including the information entered on the Evaluation: Indicator Details page.

7.3 View and Track CPA Status

This report details the CPAs for your LHD and allows you to view and track each Section CPA status, including MPRs and Indicator.

7.4 Sectional Status Report

The Sectional Status Report contains the Health Department Evaluation details for the selected Program Area, including the information entered on the Evaluation: Indicator Details page.

7.5 Section Summary Report

The Section Summary Report displays which Indicators were Met, Not Met, and Not Applicable for the selected Program Area.



8- Corrective Plan of Action (CPA)

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

LHDs that do not fully meet all essential requirements must develop CPAs for missed Indicators. When preparing CPAs, LHDs should use the Corrective Plan of Action form located on the Accreditation Web Module. A copy of this form (for reference only) can be found in [Appendix VIII](#).

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. As a result of the Exit Conference, LHDs should be aware of missed Indicators and can begin developing their CPA(s).

What to do

1. Each Indicator designated “Not Met” will require its own individual CPA form.
2. Develop the plan with input from staff.
3. Contact the Reviewer responsible for your review or state agency [Technical Assistance Contact](#) for the unmet Indicator(s) as you develop your plan(s).
4. Submit the plan(s) online through the Accreditation Web Module. Submission of the CPA will require your health officer to login to the Accreditation Web Module using their health officer account. Once logged in, the health officer may make any final edits necessary to the form and then publish the form by clicking the “Publish” button.
5. If LHD staff need assistance in developing Corrective Plan(s) of Action please contact the applicable section Reviewer(s).
6. If you have additional materials that must accompany your CPA, please send them either via email or hard copy to your applicable section Reviewer(s).
7. The Corrective Plan(s) of Action must be fully implemented within 365 days of the last day of the On-Site Review.

8.1 Create/Edit a CPA in the Accreditation Web Module

To submit CPAs in the Accreditation Web Module, click on the “View and Track CPA Status” link from the LHD home page.

The screenshot shows two main sections: 'Reports' and 'Upcoming Important Dates'. In the 'Reports' section, there is a link for 'Unpublished CPA Report' with a subtext 'Summary of all Unpublished CPAs for all program areas', and a link for 'View and Track CPA Status' which is highlighted with a red arrow. In the 'Upcoming Important Dates' section, it states 'For the selected Department:' followed by a table:

On-Site Review	9/21/2026
Submission of CPA Due: (For all indicators that are not met)	11/30/2027

A list of missed Indicators will appear and include the CPA status of “Draft”. To edit/create your CPA(s), Click the “Edit” link next to each Indicator, under the CPA Form section.

CPA Status

County Department of Public Health

Show 10 entries Search:

CPA Form	Response Form	Section	Minimum Program Requirement	Indicator	Revision	CPA Status	Response Status	Review Date
Edit PDF	* Edit PDF	Family Planning	Minimum Program Requirement #11	Indicator 11.5	1	Draft	Not Completed	
Edit PDF	* Edit PDF	Family Planning	Minimum Program Requirement #11	Indicator 11.6	1	Draft	Not Completed	
Edit PDF	* Edit PDF	Family Planning	Minimum Program Requirement #3	Indicator 3.1	1	Draft	Not Completed	
Edit PDF	* Edit PDF	Family Planning	Minimum Program Requirement #5	Indicator 5.1	1	Draft	Not Completed	

Showing 1 to 4 of 4 entries

1

The Corrective Plan of Action Form page will open. On this page, you can edit/create your health department's CPA. The top of the page includes Instructions and Guidance. Below will be the date of the CPA and your LHD Name. When the CPA is complete the Health Officer will key in their name and title.

Next, fill in the information of the correct LHD staff responsible for implementing the CPA. Include their name, title, phone number, and fax number.

Corrective Plan of Action Form

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: 8/4/2017

Local Health Department Name: County Department of Public Health

*** Your Name:**

*** Title:**



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Local Health Department Staff Responsible for Implementing Corrective Plan of Action

* Name:

* Title:

* Phone:

* Fax:

Indicator Not Met: Family Planning - Minimum Program Requirement #11, Indicator 11.5

Indicator Description: See [Michigan Title X Family Planning Standards & Guidelines 2016](#)
Pharmaceuticals/Prescriptions (29.B)

Fields to describe the CPA are available, including a projected completion date.

Corrective Plan of Action (be specific and include details)

* Describe Corrective Plan of Action:

A rich text editor interface for describing the Corrective Plan of Action. The editor includes a toolbar with icons for undo, redo, bold, italic, strikethrough, text color, background color, bulleted list, numbered list, link, unlink, source code, and a "Source" button. Below the toolbar are "Styles" and "Format" dropdown menus. The main area is a large, empty text box for entering the description.

* Projected Completion Date:



8.2 Next Steps

When an LHD submits a CPA, an automatic email will be sent to the appropriate state agency Reviewer(s). **The state agency Reviewer(s) has 30 days from the LHD's submission date** to respond to the plan(s). The options for this response are as follows:

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

In the event CPA negotiation is ongoing between the state and LHD (and exceeds the 30-day response requirement), the implementation period will be extended accordingly. Implementation of approved plans must be in place for 90 days from the date of state agency approval before an LHD may be considered for Accreditation recommendation by the Commission.

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

Responses to CPAs may be viewed and tracked via the Accreditation Web Module. Click on the "View and Track CPA Status" link from the LHD home page. The CPA Status Page will appear and list every CPA associated with your LHD. The list includes the CPA Status, Review Date, and options to view the CPA Form and Response Form.

CPA Form	Response Form	Section	Minimum Program Requirement	Indicator	Revision	CPA Status	Response Status	Review Date
View PDF	* View PDF	Family Planning	Minimum Program Requirement #11	Indicator 11.5	1	Published	Yes, No Action Required	8/23/2017 5:46:46 AM
View PDF	* View PDF	Family Planning	Minimum Program Requirement #11	Indicator 11.6	1	Published	Yes, No Action Required	8/23/2017 5:49:17 AM
View PDF	* View PDF	Family Planning	Minimum Program Requirement #3	Indicator 3.1	1	Published	Yes, No Action Required	8/10/2017 4:32:45 PM
View PDF	* View PDF	Family Planning	Minimum Program Requirement #5	Indicator 5.1	1	Published	Yes, No Action Required	8/23/2017 5:51:07 AM

Showing 1 to 4 of 4 entries



9- Procedure for Conducting Accreditation Re-evaluations of Local Health Departments

9.1 Purpose

To determine if an LHD has met the minimum program requirements (MPRs) found to be "Not Met" during the initial Accreditation evaluation.

9.2 Background

MLPHAP requires an LHD to request a re-evaluation for all MPRs and Indicators that were found to be "Not Met" between 90 days of the CPA approval date, and one year of the Accreditation evaluation. Failure to request a re-evaluation within one year will result in "Not Accredited" status.

9.3 Policy/Procedure

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

9.4 Evaluation

The evaluation will review the following:

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

9.5 Extension Policy

If it appears that the LHD will not meet the agreed upon timeframe for implementation of a CPA(s), the LHD should contact the appropriate state agency as soon as the delay is evident. If necessary, the LHD may request an extension of the CPA implementation date, documenting the extenuating circumstances that threaten the ability to meet the original date. The LHD request must be approved by the local governing entity prior to submission to the appropriate state agency. The state agency will then seek concurrence from other relevant state agencies and has final authority for approval.



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10- 180- and 90-Day CPA Process Emails

To further facilitate the CPA process between the three state agencies and the LHD, CPA reminder emails will be sent 180 and 90 days prior to the LHD's CPA final due date (365 days from the LHD's On-Site Review) if the agency still has outstanding CPAs. Emails will be sent by MPH Accreditation staff with follow-up response(s) required.

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

10.1 - 180 Day Email

To: Section Reviewer(s)

Cc: LHD Health Officer, LHD Accreditation Coordinator, Program Manager (at the state), and MDHHS Local Health Services

Subject: Accreditation – Corrective Plan of Action

Hello Reviewer(s),

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

Section:

Indicator:

We ask that you follow up with LHD Name regarding the above CPAs as soon as possible. At this point, the LHD has fewer than 180 days remaining to fully implement CPAs prior to their 365-day CPA implementation deadline. If the LHD reaches their 365-day CPA implementation deadline and the above CPAs are not fully implemented, the LHD's Accreditation status will be at risk. If you have already scheduled a re-visit, please let us know the scheduled date of that visit.

If MPH does not receive communication from you regarding the status of the above CPAs by day, date (3 days from now), the LHD's Health Officer, LHD Accreditation Coordinator, and your supervisor will be contacted to facilitate timely resolution of this matter.

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

Thank you,
Jessie Jones



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10.2 - 90 Day Email

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

Hello LHD Health Officer and Accreditation Coordinator,

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

Section: [Program Name]
Indicators: [MPRs and Indicators]

We see from our records that there is further action required before the CPA process for these MPRs is complete. At this point, LHD Name has fewer than 90 days remaining to fully implement these CPAs, including any follow-up visits needed, prior to your 1 Year Post-Review Deadline date. **This means that your LHD is fewer than ninety days away from receiving Not Accredited status.**

We ask that you communicate with your applicable section Reviewers at the state and reply to this email by date, 2 business days from now letting us know of the status of the above CPA and the plan to complete it.

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

Thank you,
Jessie Jones



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11- Accreditation Review Evaluation

Following Cycle 1, an ad hoc subcommittee of the Accreditation Commission, known as the Accreditation Quality Improvement Process (AQIP) workgroup, implemented a survey with LHDs as part of an evaluation of the Accreditation program. The AQIP survey produced 44 recommendations to improve the Accreditation process. One of these recommendations identified the need to incorporate a review evaluation component. Feedback from the participants will be used to determine if concerns expressed in the AQIP survey are being addressed. The data will help to identify training needs and aspects of the review process that may require improvement.

11.1 Procedure & Results

1. A copy of the Accreditation Review Evaluation form is included in [Appendix VIII](#).
2. The survey is completed online and can be found at this link: <https://chc.mphi.org/surveys/?s=TPPT3P47NWCTNEY8>. One survey should be completed per section reviewed. Regardless of how many individuals participated in the review, only one form per program is required.
3. MPHI will include the link to the review evaluation survey as a reminder in the email sent to the Health Officer when the On-Site Review Report is finalized. A second reminder email is also sent to help encourage health departments to complete the survey.

De-identified evaluation results will be shared with the Accreditation Commission and state agency program managers.

12- Accreditation Commission

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

12.1 Commission Review

An LHD retains its official Accredited status from one cycle to the next until the Michigan Departments of Health and Human Services, Agriculture and Rural Development, and Environment, Great Lakes, and Energy make a subsequent decision pursuant to recommendations by the Accreditation Commission. The initial presentation that occurs to the Commission once the On-Site Review is complete is simply to inform the Commissioners of the LHD's progress. No action is taken at this time. Please see [Section 13 – Becoming Accredited – What's Next](#) for subsequent steps.

12.2 Inquiry Policy

LHDs that disagree with On-Site Review findings may request an Inquiry. If the findings in question relate to Reviewer findings, the LHD is encouraged to first contact the Reviewer to seek a resolution before submitting in writing a request for an Inquiry. The first opportunity for this to occur is at the Exit Conference. However, the Inquiry may be submitted at any time during the three-year Accreditation cycle.

The purpose of the Inquiry is to convene the LHD and relevant state agency with a third party



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(Accreditation Commission Chair) to share information, discuss the issue and reach agreement.

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

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

Within two weeks of receipt of the Inquiry request, the state agency that made the original findings will submit to the Accreditation Commission Chair a written summary of their rationale for the findings and their response to the LHD's alternative recommendation.

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

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



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13- Becoming Accredited – What's Next

Once an LHD has completed the On-Site Review and subsequent CPA process, the LHD has met the requirements to be recommended for Accreditation. The CPA implementation results are then shared with the Commission at its next quarterly meeting for recommendation for approval to the Michigan Departments of Health and Human Services, Agriculture and Rural Development, and Environment Great Lakes, and Energy.

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

13.1 Accredited

An "Accredited" designation is awarded to LHDs that meet all essential indicators.

13.2 Accreditation with Commendation

An LHD is eligible for Accreditation with Commendation when it:

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

* The seven mandated services sections include: Food Service Sanitation, Communicable Disease, Hearing, Immunization, HIV/AIDS & STI, Onsite Wastewater, and Vision.

13.3 Next steps

It is suggested that LHDs consider taking the following actions upon becoming Accredited:

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



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Appendix I: Scheduling Guidance

1. Section I (Local Health Department Powers and Duties) is a one-day On-Site Review (OSR), typically scheduled on Mondays.
 - a. The optional Quality Improvement Supplement (QIS) will occur remotely. To participate in the QIS, please select the checkbox at the top of the On-Site Review Schedule page in the Accreditation Web Module. Reviewer(s) will contact you to schedule the date and time of your review.
2. Section II (Food Service Sanitation Program) will be a one to five day in-person On-Site Review. Reviewer(s) will contact the LHD before the scheduled On-Site Review to verify the exact start day and time and estimated number of days the review will take.
3. Section III (General Communicable Disease) On-Site Review will take place remotely. Please be sure to indicate a day and time for the Reviewers to contact your health department to discuss their review of your materials. Your Reviewer will verify the day and time selected prior to conducting the Exit Conference.
4. Section IV (Hearing) will be a half-day On-Site Review. The review can be scheduled concurrently with Vision, if LHD prefers. Please avoid scheduling on Fridays.
5. Section V (Immunization) will be a one-day On-Site Review at the main local health department clinic (no visits to off-site clinics) on a day when the IAP Coordinator, the Immunization Clerk, and other involved Immunization staff are available for interaction with the Reviewer.
6. Section VI (Onsite Wastewater Treatment Management) requests a minimum of two (2) days for the On-Site Review (OSR) of a single county health department. District health departments typically require additional days. Consultation with the Reviewer is suggested for confirmation of the actual number of days that are needed to complete the OSR.
7. Section VII (HIV/STI) requests half-day for the On-Site Review of a county health department. Please avoid scheduling this review on a Friday.
8. Section VIII (Vision) is a single half-day On-Site Review. Please contact the Reviewer to arrange for scheduling of the OSR prior to completing the On-Site Review Schedule in the Accreditation Web Module.
9. Section IX (Family Planning Program) is a two-day On-Site Review. FP requests LHDs schedule a family planning clinic on the first day of the visit. LHDs should schedule a full clinic with a range of visit types including initial, annual, and adolescent visits.
10. Section X (Women, Infants, and Children Program) does not require an On-Site Review. Accreditation report is based on the findings from the last WIC Management Evaluation.



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11. Section XI (Children’s Special Health Care Services) is a one-day On-Site Review. Please avoid scheduling on the fourth Thursday of the month.

SECTION	TIME REQUIRED
Section I – Local Health Department Powers and Duties and optional Quality Improvement Supplement (if applicable)	1 day
Section II – Food Service Sanitation Program	1-5 days
Section III - General Communicable Disease Control	½ day (remote)
Section IV – Hearing	½ day (Mornings 9:00 AM - 12:00 PM, or afternoons 1:00 - 4:00 PM)
Section V – Immunization	1 day
Section VI – Onsite Wastewater Treatment Management	2 days
Section VII – HIV/AIDs and STI	½ day
Section VIII – Vision	½ day
Section IX – Family Planning	2 days
Section X – Women, Infant, and Children (WIC)	N/A – no On-Site Review required
Section XI – Children’s Special Health Care Services (CSHCS)	1 day



Appendix II: Quality Improvement Supplement Specific Guidance

Quality Improvement Supplement (QIS) Review Process

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

LHDs participating in the QIS must submit documentation related to the QIS **one month** prior to their scheduled On-Site Review. All documents need to be emailed to Madeline Starr (mstarr@mphi.org) at the Michigan Public Health Institute (MPHI). Please complete the cover sheet included below to identify which documents are intended to fulfill which Indicator. Please also provide the name and contact information of a staff member who MPHI staff can contact with any questions. MPHI staff will review documentation within one week. MPHI will provide feedback and ask any needed questions during a scheduled virtual discussion. Following this discussion, MPHI will develop a draft report, including any recommendations, and provide them to Local Health Services staff following the On-Site Review.

QIS Documentation

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

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

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

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

- A written description of the department's adopted performance management system that includes:
 - 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.
 - d. A process to use data analysis and manage change for quality improvement (QI) toward creating a learning organization.



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Indicator 1.3: The agency has implemented a performance management system.

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

Indicator 1.4: The agency provides opportunities for staff involvement in the department's performance management.

- Documentation of agency staff participation in performance management training.

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

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

Indicator 2.2: The agency has engaged the local governing entity in establishing organizational policies and direction for implementing QI.

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

Indicator 2.3: 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.

- 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



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and processes, analysis of survey results, other data analyses, etc.

	This Indicator may be met by:	Documentation Required:
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
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
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.

Indicator 2.4: Program staff are involved in quality improvement activities, including professional development related to quality improvement.

- 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
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
2	Program staff at all levels are involved in quality improvement activities/projects.	Documentation of staff involved in improvement activities
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

Indicator 3.1: Program staff are involved in quality improvement activities, including professional development related to quality improvement.

- 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.



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	This Indicator may be met by	Documentation Required
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
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
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
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
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
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
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

For Questions

If you have any questions or need further information, please contact Jessie Jones at jjones@mphi.org or 517-324-8387, or Madeline Starr at mstarr@mphi.org or 517-324-8398.



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QIS Cover Sheet Staff Contact Information

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

Name:

Email:

Phone Number:

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

Indicator	File name	Policy Title/ specific page numbers that address the Indicator
<p><u>Indicator 1.1</u> Staff at all organizational levels are engaged in establishing and/or updating a performance management system.</p>		
<p><u>Indicator 1.2</u> The agency has adopted a departmentwide performance management system.¹</p>		
<p><u>Indicator 1.3</u> The agency has implemented a performance management system.²</p>		
<p><u>Indicator 1.4</u> The agency provides opportunities for staff involvement in the department's performance management.</p>		

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

Indicator	File name	Policy Title/ specific page numbers that address the Indicator
<p><u>Indicator 2.1</u> The agency has established a QI program based on organizational policies and direction.</p>		
<p><u>Indicator 2.2</u> The agency has engaged the local governing entity in establishing organizational policies and direction for implementing QI.</p>		



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<p>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.</p>		
<p>Indicator 2.4 Program staff are involved in quality improvement activities, including professional development related to quality improvement.</p>		

MPR 3: Build and support a diverse and skilled public health workforce.

Indicator	File name	Policy Title/ specific page numbers that address the Indicator
<p>Indicator 3.1 A local health department shall ensure a competent public health workforce through assessment of staff</p>		

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

² Or has plans for implementing a performance management system that incorporates the stated requirements.



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Appendix III: General Communicable Disease Control Remote Guidance

Overview

Since Accreditation Cycle 5, the Section III: General Communicable Disease Control has been conducted via an off-site remote Accreditation process. Local health departments (LHD) must upload all Section III related documents to the Michigan Health Alert Network (MIHAN) for the remote Accreditation. This will allow a standard system for sharing files during the Accreditation process.

Each LHD has an Accreditation folder in the Document Library on the MIHAN. Within the folder for each LHD there is a folder entitled "**LHD name CD Accreditation**". Access is restricted to only those local and state personnel who have been given permission to view the documents within the folder.

At least six weeks prior to the review, the LHD should ensure staff have access to upload documents to the MIHAN. See page 6 below for troubleshooting issues with the MIHAN.

The Reviewer conducting your evaluation will contact you at least three weeks before the review week of your Accreditation to provide the Accreditation Evidence Crosswalk, to request specific documents (e.g., a sample of the weekly CD logs), and to schedule a conference call exit interview. Please complete the "Accreditation Evidence Crosswalk" document and post it back to the folder. This document helps direct the Reviewer through your evidence and ensures all documents provided for each specific Indicator are reviewed. Post all supporting materials and the completed Crosswalk document to the Accreditation folder at least five business days prior to the exit interview and notify the Reviewer when the documents are ready for review.

The LHD may choose to keep the previous cycle's Accreditation materials on the MIHAN as long as Accreditation documents from the previous cycle are clearly labeled with the year and cycle number. If the LHD experiences issues with file removal, see instructions below.

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

Items to include in the Accreditation folder

Refer to the Section III MPRs and Indicators for specific suggested/required materials and documents to be placed in the folder as evidence. Provided evidence should include:

- Completed Accreditation Evidence Crosswalk document
- Electronic copies of all communicable disease policies, procedures, and protocols as specified in the Section III tool
- Electronic weekly MDSS line lists with documented review and approval (or other electronic logs – e.g., an Excel workbook)



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- Electronic copies of the annual reports, formal summaries, or website address where communicable disease trend data is maintained.
- List of stakeholders receiving the annual report or formal summary.
- Electronic versions of quarterly updates or newsletters (Special Recognition).
- A list of all disease specific protocols maintained by the LHD and 3-5 representative samples of these protocols.
- A sample of 3-5 outbreak summaries for investigations conducted during the previous 3 years.
- A sample of 3-5 fact sheets, educational materials, or guidance documents used by the LHD.
- Electronic copies of presentations given at educational venues (Special Recognition).
- List of current and up-to-date reference materials maintained by the LHD.
- Logs of professional development activities (CEU, CME, or contact hours) for at least the CD Supervisor and one other CD Nurse during the previous 3 years.
- Signature pages that represent internal review and approval for all policies, procedures, and protocols.

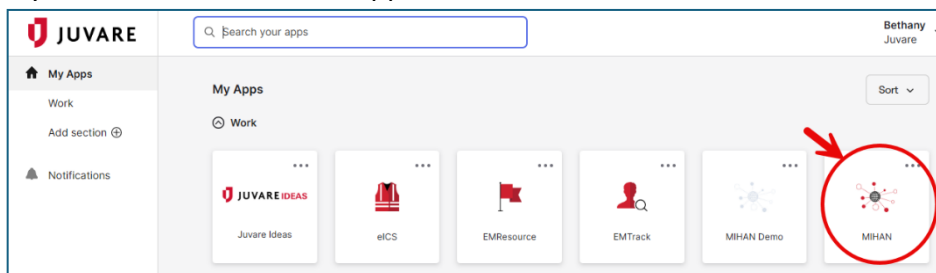
Tips:

- For materials available online, such as fact sheets, newsletters, or annual reports, provide the website address(s) in the Crosswalk document instead of uploading the materials to the MIHAN.
- If a policy or other document is evidence for more than one Indicator, it does not need to be uploaded to the MIHAN more than once. Use the Accreditation Crosswalk to indicate which files are evidence for each Indicator.
- Some health departments have found it helpful to create a new folder for each MPR and/or Indicator and upload relevant documents for each MPR into respective folders.
- Files may be uploaded in a zipped file or combined in Adobe Acrobat for easier/faster upload.
 - Note: files cannot exceed 15MB.

Michigan Health Alert Network (MIHAN): File Management for Accreditation

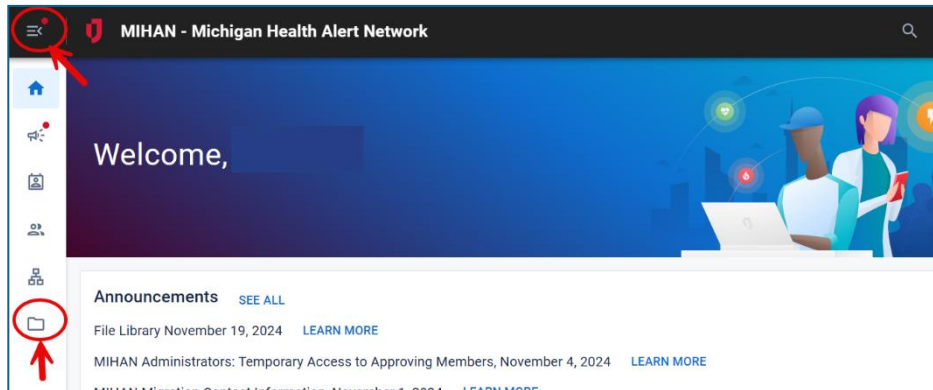
Creating Folders & Uploading Documents

1. Log in to the MIHAN (<https://login.juware.com>).
2. If you have more than one application in Juvare, select MIHAN in the initial screen:

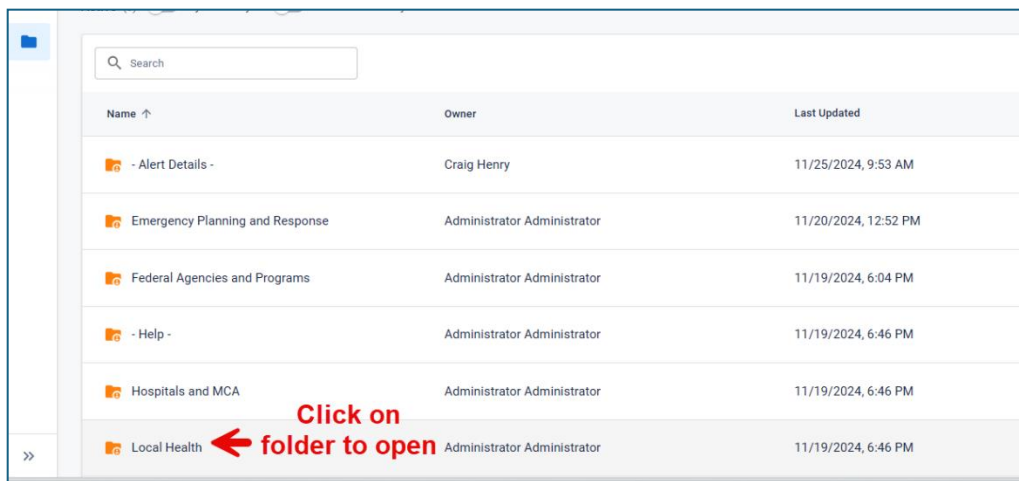


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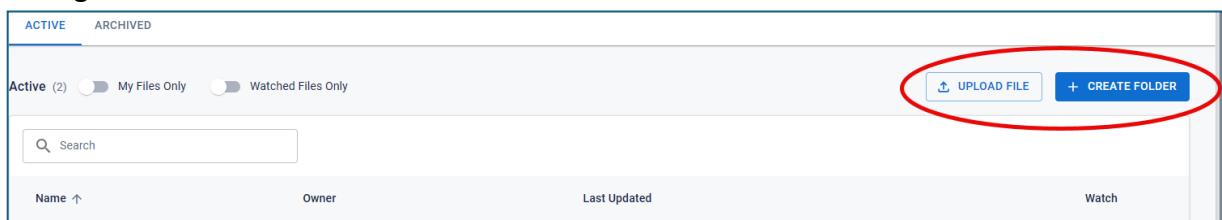
3. Ensure the “hamburger icon” in the upper left-hand corner is selected to show additional icons on the left-hand side of the screen.
4. Select the folder icon. If you do not see the folder icon, contact your local MIHAN administrator.



5. Navigate to your CD Accreditation Folder by clicking the folder name using the pathway: Local Health → INDIVIDUAL LHD → *your LHD name*.
Note: When you get to LHD named folders, you may need to go to the next page(s) to find your LHD (only 20 folders are displayed per page).




6. When you have accessed the correct folder, select ‘Upload File’ or ‘Create Folder’ on the right-hand side of the screen.



7. **Upload File:** Browse to the files you need to upload (or drag and drop files into the box). Multiple files can be selected and uploaded at one time. Select ‘upload’ to complete the upload.

Create Folder: provide a folder name (and description, if needed), then select 'create' to complete.

Upload File



Drop files here.

or

[BROWSE FILES](#)

[CANCEL](#) [UPLOAD](#)

Create Folder

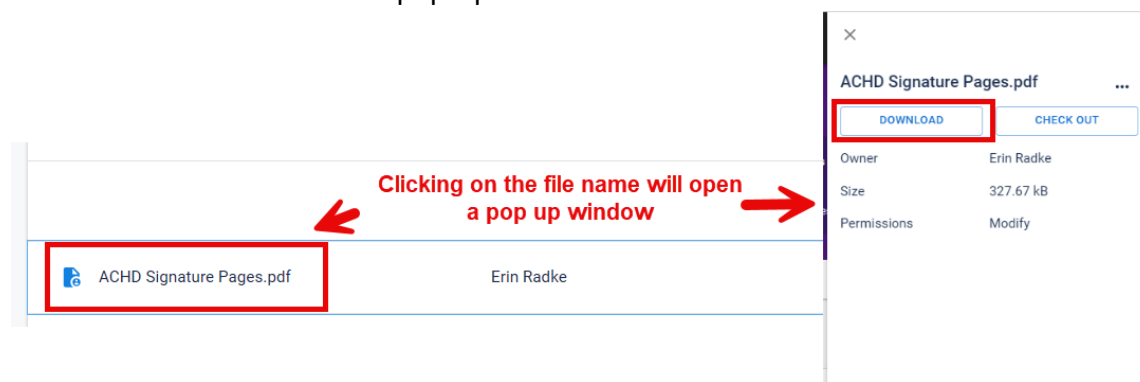
Name *

Summary

[CANCEL](#) [CREATE](#)

Viewing Documents

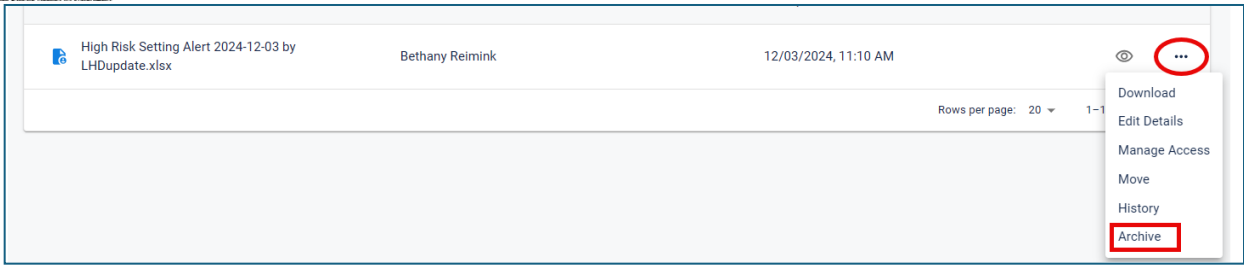
1. Navigate to the file you want to view.
2. Click on the file name you want to view to open a pop-up window on the right-hand side of the screen.
3. Click Download in the pop-up window.



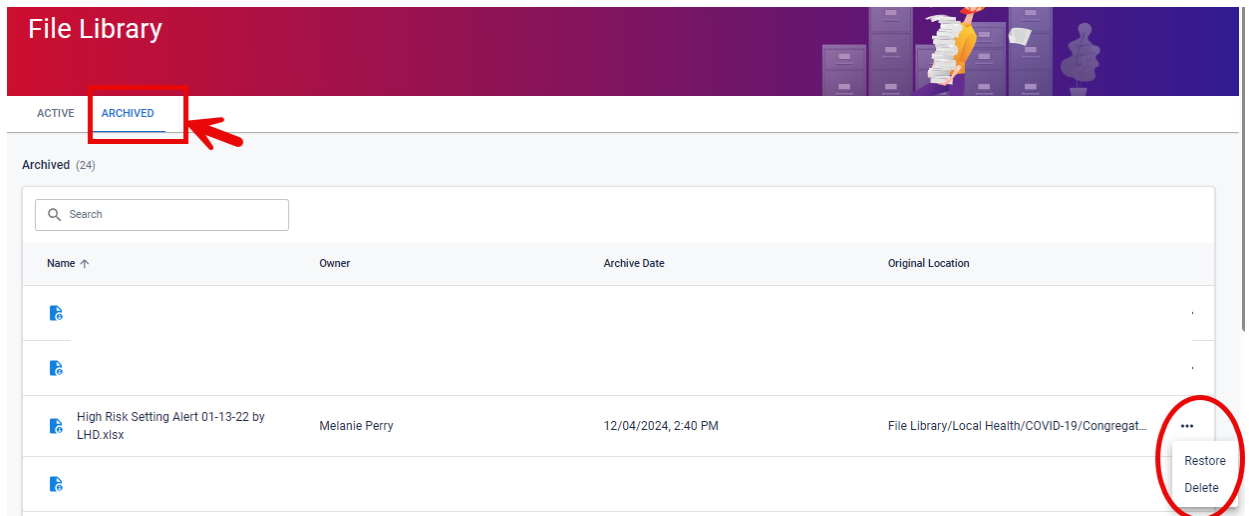
Removing Documents

1. Navigate to the file you want to remove.
2. On the right-hand side of the screen, click on the 3 dots (...) to open options for the file. Select 'Archive'.

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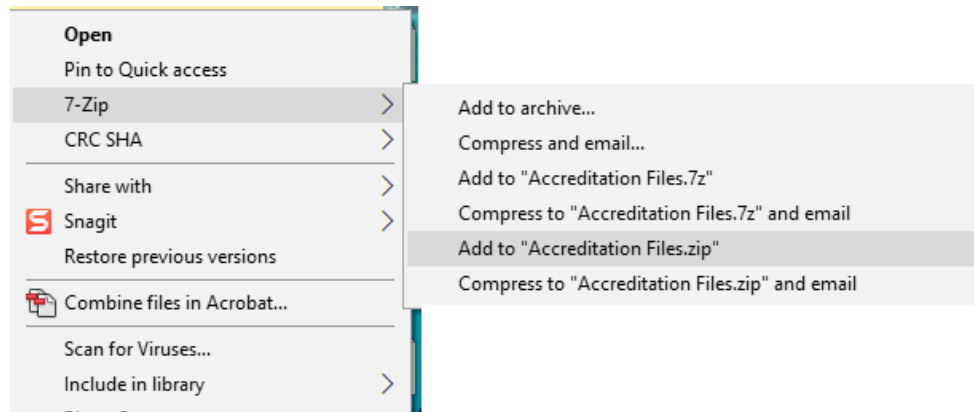


3. The file will move to an Archived folder (near top of screen). Find the file you need to delete, click on the 3 dots (...) to delete (or restore to the original folder).

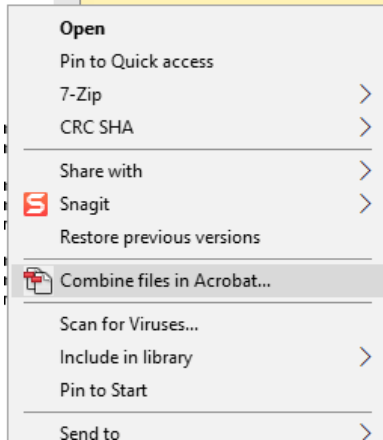


Creating Zip Files to upload to the HAN

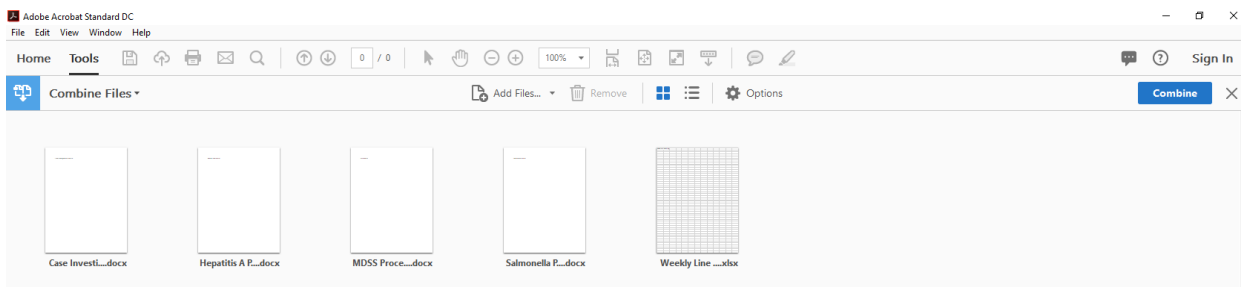
- Save all files you want to upload into a single folder.
- Right click on the folder then click on the zip program available to you (in the example below, 7-Zip is the zipping program).



- Alternatively, multiple .pdf files can be combined in **Acrobat**.
 - a. Save all files you want to upload into a single folder.
 - b. Right click on the folder then click 'Combine files in Acrobat'.



c. Click on 'Combine' in the top right-hand corner.



d. When the finished, combined file opens, save it to your computer and upload that document to the MIHAN.

Need Assistance?

For assistance with the MIHAN, contact your LHD HAN administrator (often the Emergency Preparedness Coordinator (EPC)). For additional assistance, contact the MIHAN coordinator, Denise Fleming at flemingd7@michigan.gov (517-449-8500). If Denise is unavailable, contact Terra Riddle at RiddleT1@michigan.gov (517-897-6744) or Kerry Chamberlain at ChamberlainK2@michigan.gov.



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General Communicable Disease Control: Cycle 9 Updates

MPR 1

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

Indicator	Cycle 9 Updates	Evidence that would meet Indicator
<p>Indicator 1.1</p> <p>The LHD shall be able to receive all Communicable Disease (CD) referrals from reporting entities AND maintain relevant, annually reviewed policies and procedures.</p>	<p>Updated language to focus on LHDs <i>receiving</i> CD referrals and entering in MDSS within one business day</p>	<ul style="list-style-type: none"> • Policies and procedures for receiving case reports AND entering reports into MDSS. Policies should include: <ul style="list-style-type: none"> ○ Staff responsible for MDSS entry ○ Process for receiving referrals during business hours and after hours • Evidence that policies are adhered to and reviewed annually
<p>Indicator 1.2</p> <p>The LHD collects and reviews CD surveillance data that is reported to their jurisdiction by physicians, laboratories, and other authorized reporting entities.</p>	<p>Added that documentation should include how data is collected/collated/analyzed and include staff responsible for activities</p>	<ul style="list-style-type: none"> • Instructions for generation and review of the weekly surveillance log • 3-5 samples of weekly line list (or upload all if all weeks are saved in same file) <ul style="list-style-type: none"> ○ Logs should include Reviewer name and date of review
<p>Indicator 1.3</p> <p>The LHD shall create routine reports that include aggregate CD data with interpretation for dissemination throughout the LHD's jurisdiction.</p>	<p>Previous cycle Indicator 1.4. Added clarifying language that routine reports should include an interpretation of data. If analysis of data cannot be included in the annual report, it can be included in another report or displayed on the agency's website</p>	<ul style="list-style-type: none"> • Annual (or more frequent) report of LHD's CDs that includes counts/trends plus interpretation • List of stakeholders who receive reports



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<p>Indicator 1.3 Special Recognition <i>Optional</i></p> <p>The LHD disseminates a quarterly (or more frequent) update with similar data as the annual report to community physicians, infection control, and the public.</p>	<p>Previous cycle Indicator 1.4 Special Recognition.</p> <p>Clarified that reports may be more frequent than quarterly, added that data may be displayed in a public-facing dashboard</p>	<ul style="list-style-type: none"> • Sample of quarterly (or more frequent) reports (weblink or 3-5 reports) • List of stakeholders who receive reports • Website link to public-facing dashboard that is updated at least quarterly
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MPR 2

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

Indicator	Cycle 9 Updates	Evidence that would meet Indicator
<p>Indicator 2.1</p> <p>The LHD shall conduct CD investigations as required by Michigan laws, rules, and/or executive orders AND maintain relevant, annually reviewed policies and procedures. The LHD shall electronically submit CD cases and case report forms that are complete, accurate, and timely to MDHHS by utilization of the MDSS.</p>	<p>Combines the previous cycle Indicators 2.1 and 2.2 and focuses on <i>individual case investigations</i> (moved language for outbreak investigations to Indicator 2.2)</p> <p>Includes MDSS case review from previous cycle Indicator 1.3</p>	<ul style="list-style-type: none"> • Policies and procedures for investigating individual case reports. Include: <ul style="list-style-type: none"> ○ Who initiates the investigation ○ What actions are taken ○ How MDSS is utilized ○ Appropriate timelines to be followed ○ Evidence that policies are adhered to and reviewed annually • Disease specific protocols for select diseases (3-5 protocols + a list of all protocols available) <p>NOTE: The Reviewer will pull a random sample of MDSS case reports prior to the Review for evaluation of this Indicator. The Reviewer will assess cases for evidence of case completion efforts, reporting timeline requirements,</p>



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		and efforts to update MDSS case report forms as new information is obtained.
<p>Indicator 2.1 Special Recognition <i>Optional</i> The LHD has an internal review or audit process for improvement of data quality.</p>	Previous cycle Indicator 1.3 Special Recognition	<ul style="list-style-type: none"> • Procedure for internal review process • 3-5 samples of internal review
<p>Indicator 2.1 Special Recognition <i>Optional</i> The LHD utilizes case management practices for hepatitis C (HCV) cases and linkage to care (i.e., confirmatory HCV RNA testing and/or HCV treatment start).</p>	New special recognition	<ul style="list-style-type: none"> • Policy for HCV case management practices
<p>Indicator 2.1 Special Recognition <i>Optional</i> The LHD documents HIV and diabetes statuses of confirmed TB cases.</p>	New special recognition	<ul style="list-style-type: none"> • The Reviewer will assess TB case report forms in MDSS; if a relevant policy exists, please provide
<p>Indicator 2.2 The LHD shall investigate suspect or confirmed outbreaks AND maintain relevant, annually reviewed policies and procedures on such investigations.</p>	Updated language so that Indicator now only focuses on <i>outbreak investigations</i> (language for individual case investigations found in Indicator 2.1)	<ul style="list-style-type: none"> • Policies and procedures for outbreak investigations <ul style="list-style-type: none"> ○ Include documentation of staff roles and responsibilities • Outbreak investigation folder or log • Reports (6-point narratives and/or After Action Reports) from outbreaks co-investigated by EH and CD • Evidence that policies are reviewed annually <p>Note: The Reviewer will review MDSS aggregate case reports marked as outbreaks.</p>



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<p>Indicator 2.2 Special Recognition <i>Optional</i> The LHD maintains regular collaboration meetings with CD and EH staff (at least quarterly).</p>	<p>New special recognition</p>	<ul style="list-style-type: none"> • Agendas, minutes, or other documentation of quarterly (or more frequent) CD/EH collaboration meetings
<p>Indicator 2.2 Special Recognition <i>Optional</i> The LHD manages large outbreaks or monitoring events using the MDSS Outbreak Management System (OMS).</p>	<p>Previous cycle Indicator 2.3 Special Recognition</p>	<ul style="list-style-type: none"> • Outbreak file contains a list of outbreaks or monitoring events from OMS or other evidence that OMS was used in an outbreak response.
<p>Indicator 2.3 The LHD shall notify MDHHS immediately of a suspected CD outbreak in their jurisdiction and provide finalized data for reporting.</p>	<p>Updated language to include reporting of finalized outbreak data</p> <p>Use of MDSS aggregate for outbreak reporting was previously considered special recognition but is now required</p>	<ul style="list-style-type: none"> • Policy or procedure for outbreak investigations includes: <ul style="list-style-type: none"> ○ MDHHS is notified of outbreaks within 24 hours by phone, fax, email, or MDSS ○ MDHHS is notified via phone or email for non-routine outbreaks (outbreaks other than ILI or GI outbreaks in congregate settings) ○ Staff responsible for notification ○ Information to be shared with MDHHS (possible pathogen, source, number ill, facility) ○ Outbreak documentation in MDSS aggregate form including final outbreak data. <p>Note: The Reviewer will review MDSS aggregate case reports marked as outbreaks.</p>
<p>Indicator 2.4 The LHD shall complete and submit the necessary foodborne or waterborne outbreak investigation forms.</p>	<p>Previously Indicator 3.4</p>	<p>The Reviewer will pull 52.14 forms submitted by the LHD; LHDs may be asked for additional NORS forms that may not have been received by MDHHS.</p>



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MPR 3

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

Indicator	Cycle 9 Updates	Evidence that would meet Indicator
<p>Indicator 3.1 The LHD 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.</p>	<p>Combines previous cycle Indicators 3.1 and 3.2</p>	<ul style="list-style-type: none"> • Policies and procedures for case follow-up and completion and guidance to prevent disease transmission <ul style="list-style-type: none"> ○ Evidence that policies are reviewed annually • Disease control guidelines or other guidance materials to assist in the control of disease spread (e.g., Norovirus Control Guidelines in Nursing Homes) that can be shared with community partners • Education materials, factsheets, social media postings, or other guidance that assist the LHD with prevention of disease transmission • <i>Note: documents or links to web-based resources are acceptable</i>
<p>Indicator 3.1 Special Recognition <i>Optional</i> The LHD provides CD presentations to educational venues such as conferences or community health education fairs (at least annually).</p>	<p>Previous cycle Indicator 3.2 special recognition</p>	<ul style="list-style-type: none"> • CD presentations to educational venues such as conferences or community health education fairs
<p>Indicator 3.1 Special Recognition <i>Optional</i> The LHD meets with healthcare stakeholders such as LTC facilities and hospital infection</p>	<p>New special recognition</p>	<ul style="list-style-type: none"> • Agendas, minutes, or other documentation of quarterly (or more frequent) LHD/healthcare meetings



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preventionists to provide CD updates (at least quarterly).		
<p>Indicator 3.2</p> <p>The local health department maintains adequately prepared staff capable of enforcing Michigan law governing the control of CDs.</p>	<p>Previous cycle Indicator 3.3. Updated language to include: 1) new staff orientation guidance, 2) routine collaboration between CD/EH/EPC staff, 3) attendance of the MDHHS CD Conference, and 4) staff awareness for elevating situations that may require legal intervention (such as public health threat to others, quarantine order, enforcement of reporting requirements)</p>	<ul style="list-style-type: none"> • Documentation of CD staff (epi, supervisors and/or nurses) orientation guidance (i.e., manual or checklist) • Policies and procedures that include: <ul style="list-style-type: none"> ○ A description of CD/EH/EPC roles and collaboration ○ Process for frontline CD staff to notify the Health Officer/Medical Director of situations that may require legal intervention ○ Evidence that policies are reviewed annually • List of current and up-to-date reference materials • Documentation of CD staff participation in professional development activities, conferences, seminars, and/or trainings (i.e., CEU certificates or list of activities attended)
<p>Indicator 3.2 Special Recognition <i>Optional</i></p> <p>The LHD staff attend relevant public health webinars, trainings, or conferences (e.g., Public Health Law Webinars, Annual TB Day Conference, or health equity or implicit Bias trainings)</p>	<p>New special recognition</p>	<ul style="list-style-type: none"> • Documentation of staff participation in relevant webinars/trainings/conferences



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General Communicable Disease Control Accreditation Evidence Crosswalk

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

MPR 1

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

Indicator	File name / web address LHD is submitting as evidence for this Indicator	Policy title / specific page numbers that address Indicator
<p>Indicator 1.1 The LHD shall be able to receive all Communicable Disease (CD) referrals from reporting entities AND maintain relevant reviewed policies and procedures.</p>		
<p>Indicator 1.2 The LHD collects and reviews CD surveillance data that is reported to their jurisdiction by physicians, laboratories, and other authorized reporting entities.</p>		
<p>Indicator 1.3 The LHD shall create routine reports that include aggregate CD data with interpretation for dissemination throughout the local health department's jurisdiction.</p>		
<p>Indicator 1.3 <i>Special Recognition</i> The LHD disseminates a quarterly (or more frequent) update with similar data as the annual report to community physicians, infection control, and the public.</p>	<i>Optional</i>	<i>Optional</i>



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MPR 2

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

Indicator	File name / web address LHD is submitting as evidence for this Indicator	Policy title / specific page numbers that address Indicator
<p>Indicator 2.1 The LHD shall conduct CD investigations as required by Michigan laws, rules, and/or executive orders AND maintain relevant, annually reviewed policies and procedures. The LHD shall electronically submit CD cases and case report forms that are complete, accurate, and timely to MDHHS by utilization of the MDSS.</p>		<p>NOTE: The Reviewer will pull a random sample of MDSS case reports prior to the Review for evaluation of this Indicator.</p>
<p>Indicator 2.1 <i>Special Recognition</i> The local health department has an internal review or audit process for improvement of data quality.</p> <p>The LHD utilizes case management practices for hepatitis C (HCV) cases and linkage to care (i.e., confirmatory HCV RNA testing and/or HCV treatment start).</p> <p>The LHD documents the HIV and diabetes statuses of confirmed TB cases.</p>	<p><i>Optional</i></p>	<p><i>Optional</i></p>
<p>Indicator 2.2 The LHD shall investigate suspect or confirmed outbreaks AND maintain relevant, annually</p>		



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<p>reviewed policies and procedures on such investigations.</p>		
<p>Indicator 2.2 <i>Special Recognition</i> The LHD maintains regular collaboration meetings with CD and EH staff (at least quarterly). The LHD manages large outbreaks or monitoring events using the MDSS OMS.</p>	<p><i>Optional</i></p>	<p><i>Optional</i></p>
<p>Indicator 2.3 The LHD shall notify MDHHS immediately of a suspected CD outbreak in their jurisdiction and provide finalized data for reporting.</p>		<p>Note: The Reviewer will review MDSS aggregate case reports marked as outbreaks.</p>
<p>Indicator 2.4 The LHD shall complete and submit the necessary foodborne or waterborne outbreak investigation forms.</p>		<p>Note: The Reviewer will pull 52.14 forms submitted by the LHD; LHDs may be asked for additional NORS forms that may not have been received by MDHHS.</p>



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MPR 3

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

Indicator	File name / web address LHD is submitting as evidence for this Indicator	Policy title / specific page numbers that address Indicator
<p>Indicator 3.1 The LHD 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.</p>		
<p>Indicator 3.1 <i>Special Recognition</i> The LHD provides CD presentations to educational venues such as conferences or community health education fairs (at least annually). The LHD meets with healthcare stakeholders (such as LTCs and hospital ICPs) to provide CD updates (at least quarterly).</p>	<i>Optional</i>	<i>Optional</i>
<p>Indicator 3.2 The LHD maintains adequately prepared staff capable of enforcing Michigan law governing the control of CDs.</p>		
<p>Indicator 3.2 <i>Special Recognition</i> The LHD staff attend relevant public health webinars, trainings, or conferences (e.g., Public Health Law Webinars, Annual TB Day Conference, health equity or implicit bias trainings).</p>	<i>Optional</i>	<i>Optional</i>



Appendix IV: HIV/AIDS & STI Specific Guidance

The HIV/STI Program will be following the [Cycle 9 On-Site Review Expectations Guidance](#) document provided by the Michigan Local Public Health Accreditation Program.

The On-Site Review will be centered around the HIV/AIDS & STI [Cycle 9 Minimum Program Requirement Indicator Guide](#) and how the Local Health Department's processes and policies fulfill each MPR/Indicator.

Site Review Format:

- Introductions
 - Names and titles of Accreditation Reviewers and Local Health Department Staff in attendance
- Tour of the Local Health Department
- Review of MPRs/Indicators
 - Discuss Local Health Department's processes and any additional documentation or policies relevant to MPRs
- Support Discussion
 - Identify needed supports and provide general feedback for the Local Health Department
- Exit Interview
 - Summary of Site Review, recommendations, and determinations (Met, Not Met, or Met with Conditions) for each MPR

Please submit any Technical Assistance needs from the On-Site Review on [SHOARS](#).

HIV/STI Pre-Material

Pre-material is to be submitted digitally at least one week before the On-Site Review date. Please reference the Documents Required sections of the HIV/AIDS & STI Cycle 9 Minimum Program Requirement Indicator Guide to determine appropriate uploads. These materials may be uploaded either to the Accreditation Portal or to SHOARS on the Local Health Department's organization page. If you need assistance submitting documentation, please reach out to the Accreditation Reviewers.

[STI/HIV Operations and Resource System \(SHOARS\) \(michigan.gov\)](#)



Appendix V: Family Planning Specific Guidance

As a Title X federally funded Family Planning (FP) program, Title X requires continuous program compliance and monitoring. The Family Planning program will conduct Cycle 9 Title X program reviews for Local Health Department (LHD) Projects in collaboration with the Michigan Local Public Health Accreditation Program (MLPHAP) and within the MLPHAP Accreditation schedule. The FP Program requests that specific materials be submitted as documentation of program compliance at least two (2) weeks prior to the scheduled review and requests specific materials be available on site at the time of the review. These materials are listed below. The FP Program requests that LHDs projects schedule a full clinic on the first day of the review to facilitate clinical and program observation.

Family Planning Pre-materials:

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

1. Curricula vitae or resumes of project director and medical director
2. Family Planning manuals including:
 - a. Family Planning General Policy manual
 - b. Current Fee schedule and Sliding fee schedule
 - c. Family Planning Billing & Collections Policy (if not in general policy manual)
 - d. Clinical Protocols (Contraceptive, STI and Breast & Cervical Screening protocols)
 - e. Current Drug Formulary
 - f. Drug Inventory Policy and Procedures (if not in general policy manual)
 - g. Current referral agreements for paid referrals (LARC providers, etc.)
 - h. Current contracts with contractual staff (Contractual provider, medical director, etc.)
 - i. Roster for Family Planning Advisory Committee (FPAC) and Information and Education (I&E) Advisory Committee and minutes of last (2) two meetings for each
3. Copy of Clinical Laboratory Improvement Amendments (CLIA) license for laboratory
4. Current Referral listings

The following materials are to be available on site for the combined reviews:

1. Client medical records:
 - a. To be chosen randomly, based on visit type, abnormal pap follow-up, adolescent status or choice of contraceptive method
 - b. Please plan to have a staff member available at the review to be able to spend a few hours with clinical Reviewer assisting the chart review
2. Current organizational chart for agency (include a detailed Family Planning program organization chart, or a listing of staff names, positions, and FTEs for the Family Planning staff)
3. Copy of practice license for Family Planning staff nurses and providers
4. Copy of Drug Control license for each prescribing provider for each clinic site
5. CPR certification for all licensed clinical staff
6. Documentation of Title X Orientation and In-service trainings for all staff
7. Documentation of quality assurance activities including medical audits, chart audits, and quality assurance committee minutes/staff minutes/memos that address quality



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assurance issues with staff

8. Review of Billing records:

- a. To be randomly selected, based on client mix; self-pay, at least (1) one adolescent self-pay, Fee for Service (FFS) Medicaid, Medicaid Health Plan, private Insurance, (1) one with co-pay, if available
- b. Billing record review to include the visit record, the bill generated, and reimbursement if available
- c. Please plan to have a staff member available at the review to be able to spend an hour with the administrative Reviewer assisting review of the billing process



Appendix VI: Children's Special Health Care Services (CSHCS) Specific Guidance

Children's Special Health Care Services Pre-materials:

All Children's Special Health Care Services (CSHCS) pre-materials should be sent directly to the CSHCS program using the secure electronic method of communication designated by CSHCS (currently known as DMP).

CSHCS MPRs and Indicators: What LHDs need to know for Cycle 9

Michigan Department of Health and Human Services' Children's Special Health Care Services (CSHCS) program, in partnership with the Michigan Public Health Institute, has embarked on a process to revise the CSHCS Michigan Local Public Health Accreditation Program Minimum Program Requirements (MPRs) and Indicators for Cycle 9 of Accreditation. The workgroup, in cooperation with stakeholders, assessed the strengths and limitations of the current CSHCS MPRs and Indicators, and made revisions as necessary to ensure that they are meaningful, measurable, and efficient. Below is a summary of changes made to the draft MPRs and Indicators for Cycle 9, along with the reason behind the changes. Before MPRs and Indicators are finalized, the Accreditation Program's Standards Review Committee review and discuss the draft, then hold an official vote to approve changes. If you have any questions about the changes, please contact Amanda Larraga at LarragaA@michigan.gov.

MPR/ Indicator	Description of Change:	Reasoning for Change:
1.1	Removed requirement of full staff roster being submitted in advance of review. Removed requirement of staff roster change correspondence and personnel records submission. Updated Caseload ranges on visual chart.	Accreditation Specialist receives notification of staffing changes to Contacts at a Glance and tracks everything on a spreadsheet. Accreditation Specialist will ask for roster information on site only if needed. Caseload ranges adjusted to match data from age 26 expansion and 22% allocation increase for LHDs.
1.2	Updated from "printed certificate" to LHD New Staff Orientation form and removed requirement to submit in advance of Accreditation. Removed requirement of CSHCS Annual Meeting attendance sign in sheets.	The LHD New Staff Orientation Verification Form replaced the need for printed certificates and is submitted to Accreditation Specialist once training is completed, which is tracked in a spreadsheet by the Accreditation Specialist. CSHCS Annual Meeting attendance is now in a hybrid format and is recorded for staff to view at any time. Accreditation Specialist can obtain viewing and attendance records through the meeting facilitator.
2.1	Added language "During or prior to" onsite review for staff to demonstrate proficiency in CSHCS Database.	Adding this language will allow more flexibility to Reviewers of when this may be assessed with the possible involvement of CSHCS analyst.



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MPR/ Indicator	Description of Change:	Reasoning for Change:
	Revised list of what staff will be asked to identify within the CSHCS Database.	Updated list of what to identify in the Database is more relevant and helpful to LHD staff.
2.2	Added language "During or prior to" onsite review for staff to demonstrate proficiency in the Document Management Portal (DMP). Added list of what staff will be asked to identify within DMP.	Adding this language will allow more flexibility to Reviewers of when this may be assessed with the possible involvement of CSHCS analyst. Adding list of what to identify in the DMP is more relevant and helpful to LHD staff.
2.3	Changed "should" be submitted in advance of review to "must".	Submission of client record is essential for Reviewers to have in advance of onsite review.
2.4	Added evaluation question regarding electronic formats used to communicate with families.	Added question reflects conversations that Reviewers regularly have with LHD staff currently on onsite review day.
2.5	Added onsite interview with staff regarding accessibility for CSHCS families. Added evaluation questions regarding accessibility and how often families come to LHD in person.	Added interview and questions reflect conversations that Reviewers regularly have with LHD staff currently on onsite review day.
3.1	Added language regarding staff familiarity of the CSHCS Comprehensive Agreement (CA) and tied in existing policy and procedure requirement into this Indicator.	Reviewers noted that policy and procedure requirements were occasionally missed when not tied back to an actual Indicator. This connection aims to resolve any further oversight.
3.2	Changed "should" be submitted in advance of review to "must".	Submission of policies and procedures are essential for Reviewers to have in advance of onsite review.
3.3	Adjusted list of required documentation examples. Refined language within evaluation questions.	More comprehensive examples of documentation added to provide more clarity. Evaluation questions adjusted for increased relevancy and more meaningful conversations.
4.1	Tied in existing policy and procedure requirement regarding diagnostic evaluations into this Indicator.	Reviewers noted that policy and procedure requirements were occasionally missed when not tied back to an actual Indicator. This connection aims to resolve any further oversight.
4.2	Additional examples of referrals and partnerships added.	Additions further highlight possible efforts of LHD staff.
4.3	Additional examples of documentation added.	Additions further highlight possible efforts of LHD staff.



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MPR/ Indicator	Description of Change:	Reasoning for Change:
5.1	Tied in existing policy and procedure requirement regarding renewal follow up into this Indicator.	Reviewers noted that policy and procedure requirements were occasionally missed when not tied back to an actual Indicator. This connection aims to resolve any further oversight.
5.2	Inserting “diverse” follow up activities to attempt to contact families. Added evaluation question asking about diverse attempts to contact.	Changes reflect conversations that Reviewers regularly have with LHD staff currently on onsite review day.
5.3	Inserting “diverse” follow up activities to attempt to contact families. Added evaluation question asking about diverse attempts to contact.	Changes reflect conversations that Reviewers regularly have with LHD staff currently on onsite review day.
6.1	Tied in existing policy and procedure requirement regarding rights and responsibilities into this Indicator.	Reviewers noted that policy and procedure requirements were occasionally missed when not tied back to an actual Indicator. This connection aims to resolve any further oversight.
6.2	Moved examples of TEFRA (4.2) and Language Interpretation (2.5) to other Indicators. Added evaluation question regarding care and service needs goals in the Plan of Care.	Examples were more appropriate in other Indicators. Evaluation question focuses in on creating goals in the Plan of Care based on care and service needs.
6.3	Removed “when already in contact with the family” regarding transition assistance. Adjusted examples of further documentation and evaluation questions to reflect current best practices.	Aligns with current expectations of reaching out to families of clients during transition. Provides more clear examples of current documentation currently utilized.
6.4	Language made more concise. Updated examples of further documentation to include current NEMT Authorization Addendum.	Updates align with the current form in use.
6.5	Added Out of State Approvals report to examples of further documentation.	Providing additional documentation as another way to meet this Indicator.
6.6	Added “Plan of Care developed by a registered nurse or licensed social worker, including all essential elements.” Added “appropriate” client specific billing.	Changes reflect current expectations and conversations that Reviewers regularly have with LHD staff on onsite review day.



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MPR/ Indicator	Description of Change:	Reasoning for Change:
	Added evaluation question regarding the individualization of a Plan of Care.	



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Appendix VII: Technical Assistance Contacts

	SECTION	NAME	TELEPHONE	EMAIL
I	LHD Powers & Duties	Jim Rutherford	517-230-4095	RutherfordJ2@michigan.gov
	Quality Improvement Supplement (QIS)	Madeline Starr	517-324-8398	mstarr@mphi.org
II	Food Service Program	Shane Green	517-930-6737	Greens2@michigan.gov
III	General Communicable Disease Control	Shannon Johnson	517-284-4941	johnsons61@michigan.gov
IV	Hearing	Jennifer Dakers	517-719-1515	dakersj@michigan.gov
V	Immunization	Barbara Day Heidi Loynes	313-378-4533	dayb1@michigan.gov LoynesH@michigan.com
VI	Onsite Wastewater Treatment Management	Tanya Rule	906-458-3812	RuleT@michigan.gov
VII	HIV/AIDS and STI	Hanya Ombina Elizabeth (Liz) Gregoire	517-285-4167 517-275-1782	OmbimaH@michigan.gov GregoireE@michigan.gov
VIII	Vision	Jennifer Dakers	517-719-1515	dakersj@michigan.gov
IX	Family Planning	Quess Derman	517-335-8696	dermanb@michigan.gov
X	Women, Infants, and Children (WIC)	Nancy Erickson	517-335-9562	ericksonn@michigan.gov
XI	Children's Special Health Care Services (CSHCS)	Amanda Larraga	517-241-7189	LarragaA@michigan.gov



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Appendix VIII: Accreditation On-Site Review Evaluation

Please complete this form online at: <https://chc.mphi.org/surveys/?s=TPPT3P47NWCTNEY8>

Local Health Department: _____

Date: _____

Section Evaluated: _____

Sections include: I=Local Health Department Powers and Duties, II=Food Service Sanitation, III=General Communicable Disease Control, IV=Hearing, V=Immunization, VI=On-Site Sewage Treatment Management, VII= HIV/AIDS and Sexually Transmitted Disease, VIII=Vision, IX=Family Planning, X=Women, Infants, and Children Administration, and XI=Children's Special Health Care Services

Number of Accreditation Reviewers at the On-Site Review: _____

Number of LHD staff participating in this evaluation: _____

Directions: Circle the number that corresponds to your response, using the following scale: 1 = Strongly disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree NA = Does not apply or leave blank if you prefer not to answer	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. Technical assistance was offered to LHD prior to the On-Site Review.	1	2	3	4	5	NA
2. Technical assistance offered met the needs of the LHD.	1	2	3	4	5	NA
3. Any program or Accreditation tool changes were communicated well in advance of the review.	1	2	3	4	5	NA
4. The Reviewer(s) provided a clear overview of "what will occur" and "how the LHD will be evaluated" either on-site or in advance of the visit.	1	2	3	4	5	NA
5. Reviewer(s) conduct was professional throughout visit.	1	2	3	4	5	NA
6. The Reviewer(s) maintained a quality improvement focus.	1	2	3	4	5	NA
7. The Reviewer(s) provided information about available capacity building assistance opportunities as necessary.	1	2	3	4	5	NA
8. The Reviewer(s) are knowledgeable on the subject of their section.	1	2	3	4	5	NA
9. The Reviewer(s) provided input and reporting consistent with the current Accreditation tool.	1	2	3	4	5	NA
10. Recommendations provided by the Reviewer(s) are actionable.	1	2	3	4	5	NA
11. The Reviewer(s) allowed for an appropriate amount of interaction.	1	2	3	4	5	NA
12. The Reviewer(s) listened carefully to LHD responses to questions.	1	2	3	4	5	NA
13. The Reviewer(s) discussed program strengths and weaknesses.	1	2	3	4	5	NA
14. The Reviewer(s) made recommendations for improvement as necessary.	1	2	3	4	5	NA
15. The Reviewer(s) encouraged LHD questions and feedback.	1	2	3	4	5	NA
16. Did the Reviewer(s) conducted an Exit Interview?	No			Yes		
17. Overall, the Reviewer(s) did an excellent job.	1	2	3	4	5	NA



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18. Has the LHD received the On-Site Review Report?	No			Yes		
19. The On-Site Review Report provided for this section is very helpful to use to improve the quality of this program.	1	2	3	4	5	NA
20. The written On-Site Review Report made use of the "Special Recognition" and/or "Recommendations for Improvement" categories.	1	2	3	4	5	NA
21. The review findings were compatible with my agency's self-assessment.	1	2	3	4	5	NA
22. Our LHD knows who to reach out to for further assistance for this program.	1	2	3	4	5	NA

Pre-Review Self-Assessment Processes						
Please answer these questions if you utilized the pre-review self-review process offered by MDARD.						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. The Self-Assessment process was useful.	1	2	3	4	5	NA
2. The Self-Assessment process was user-friendly.	1	2	3	4	5	NA
3. The Self-Assessment process helped my agency successfully prepare for our On-Site Review.	1	2	3	4	5	NA
4. Materials were provided in advance with sufficient time to conduct self-assessment activities.	1	2	3	4	5	NA
5. I was satisfied with the Self-Assessment process.	1	2	3	4	5	NA
Please provide any additional feedback you have on the self-assessment process:						

Off-Site Review Processes						
Please answer these questions regarding the off-site/virtual review process used by Communicable Disease and/or the QIS.						
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
1. The guidance for submitting documentation was clear.	1	2	3	4	5	NA
2. I feel like the level of interaction with the Reviewer(s) prior to and during the off-site/virtual review process was appropriate.	1	2	3	4	5	NA
3. I am satisfied with the off-site/virtual review process.	1	2	3	4	5	NA
Please provide any additional feedback you have on the off-site/virtual review process:						



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1. List the strong points of the review:

2. List areas of the review in need of improvement:

3. Any additional comments, concerns, or suggestions.

4. Who may we contact for additional information?

Note: if you would like to be contacted about your responses, please include name and telephone number below.

Survey Respondent Name: _____

Telephone: (____) _____



Appendix VIII: Corrective Plan of Action Form

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

Instructions and Guidance:

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



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

Local Health Department Staff Responsible for Implementing Corrective Plan of Action
 Name:
 Title:
 Phone:
 Fax:

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

Corrective Plan of Action (be specific and include details)

Describe Corrective Plan of Action:

Rich text editor toolbar with icons for undo, redo, bold, italic, underline, and list. The main text area is currently empty.

Projected Completion Date:

Please Explain how the Corrective Plan of Action will correct the deficiency:

Rich text editor toolbar with icons for undo, redo, bold, italic, underline, and list. The main text area is currently empty.

Are there additional materials accompanying this CPA:

Yes No

Electronic Signature:

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

[Return to CPA Page](#)