



# FY2024 PEER REVIEW

Participant Name: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewer Name: \_\_\_\_\_

**2.1: Is there a valid Freedom of Choice (FOC) form in the record for the review period? (Recommendation)**

Yes    No    N/A

Comments:

**5.1: Did the Supports Coordinator (SC) contact the participant/guardian prior to assessments, home visits and/or planning meetings to ensure the date(s), time(s) and location(s) were convenient for the participant/guardian? (New Citation)**

Yes    No    N/A

Comments:

**6.1: Did the Waiver Agency (WA) complete the Initial Assessment (IA) and/or Re-Assessments (RA) in accordance with MDHHS policy and contract requirements? (Recommendation)**

Yes    No    N/A

Comments:

**6.6: Did the Supports Coordinator (SC) assess the participant for all risks including environmental and home-based risks, educate the participant/guardian on assessed/identified risks, offer modifications to promote safety and independence, and provide the participant/guardian the opportunity to manage risk throughout care planning and service delivery? (New Citation)**

Yes    No    N/A

Comments:

**6.7: If the Supports Coordinator (SC) identified the use of restraints or seclusion, did the SC evaluate, address, and offer alternatives to the use of restraints or seclusion? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**7.1: Did the Medication Record include all prescribed medications? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**7.2: Did the Medication Record include the name, prescribing physician name (as indicated on the prescription bottle), purpose, strength/dose, frequency, and route for all medications? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**7.7: Did the Supports Coordinator (SC) address issues the participant had with medication regimen compliance and take action to reduce the risk of medication mismanagement? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**8.4: Did the Person-Centered Service Plan (PCSP) identify the participant's health and welfare issues, needs, and risks as preferred by the participant and as needed for continued monitoring by the Supports Coordinator (SC)? (Recommendation)**

Yes    No    N/A

Comments:

**8.5: Did the Person-Centered Service Plan (PCSP) include the process for minimizing risk factors, planning, and supporting the participant? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**8.9: Did the Supports Coordinator (SC) contact and collaborate in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**8.10: Did the Person-Centered Service Plan (PCSP) include outcome evaluations for each goal in accordance with MDHHS policy and contract requirements? (Recommendation)**

Yes    No    N/A

Comments:

**8.12: Is the person responsible for monitoring the Person-Centered Service Plan (PCSP) identified in the plan?**

(Recommendation)

Yes    No    N/A

Comments:

**9.5: Did the Supports Coordinator (SC) authorize a change in a MI Choice Program service(s) in accordance with MDHHS policy and contract requirements, or provide the participant/guardian with appropriate alternatives?**

(Recommendation)

Yes    No    N/A

Comments:

**9.6: Did the authorized MI Choice Program services meet service standard requirements? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**10.2: Did the Supports Coordinator (SC) assess the presence of, or the need for, non-waiver services, and then, as preferred by the participant, provide the participant/guardian with information and/or assistance linking to non-waiver services or resources, and/or provide ongoing coordination and monitoring? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**10.3: If the participant/guardian experienced difficulty in securing a non-waiver/arranged service(s), did the Supports Coordinator (SC) continue to assist as warranted? (New Citation)**

Yes    No    N/A

Comments:

**10.8: Did your Supports Coordinator help you to access resources when requested, including calling to coordinator or arrange care with your doctor(s), skilled services, etc. as applicable? (New Citation)**

Yes    No    N/A

Comments:

**11.1: Did the Supports Coordinator (SC) contact the newly-enrolled participant/guardian to ensure service delivery in accordance with MDHHS policy and contract requirements? (New Citation)**

Yes    No    N/A

Comments:

**11.2: Did the Supports Coordinator (SC) contact the participant/guardian/designated person for follow-up and monitoring as specified in the Person-Centered Service Plan (PCSP) in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**13.1: Did the record contain a complete and up-to-date contingency plan in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)**

Yes    No    N/A

Comments:

**13.2: Did the participant/guardian receive a copy of the contingency plan in accordance with MDHHS policy and contract requirements? If no, were they offered a copy and declined? (New Citation)**

Yes    No    N/A

Comments:

**14.3: Critical Incidents - Did the Supports Coordinator (SC) take appropriate action and discuss methods to prevent further occurrence with the participant/guardian? (New Citation)**

Yes    No    N/A

Comments:

**14.4: Did the Waiver Agent (WA) enter, report, and provide updates to the critical incident portal in accordance with MDHHS policy and contract requirements? (Multi-Year Citation)**

Yes    No    N/A

Comments:



**15.2: Was the Adverse (Advance) Action Notice (AAN) and/or Adverse Benefit Determination (ABD) complete, and accurate? (Multi-Year Citation)**

Yes      No      N/A

Comments:

Supports Coordinator must sign this form confirming they have reviewed the results of peer review and corrected any omissions, errors, and followed through with any recommendations.

RN Supports Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

SW Supports Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_