FY2025 PEER REVIEW

Participant Name: _____ Date: _____

Reviewer Name: _____

COMPASS ID: _____ Date of Birth: _____ Waiver Start Date: _____

1.1. Was the Nursing Facility Level of Care Determination (NFLOCD) adopted from a long-term care provider or conducted within 7 days prior to or the day of initial enrollment and/or re-enrollment and entered into CHAMPS as required by MDHHS and the contract? (New Citation)

◯ Yes ◯ No

Comments:

1.2. Did the Waiver Agent (WA) validate the accuracy of the Nursing Facility Level of Care Determination (NFLOCD) assessed Door and ensure the validity of the NFLOCD(s) in CHAMPS? (Recommendation)

◯ Yes ◯ No

Comments:

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

◯ Yes ◯ No

Comments:

3.4. Were agency specific forms accurate, complete, and did they conform to MDHHS policy and contract requirements? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

3.5 Were alleged privacy breaches investigated, reported, and conform to MDHHS policy and contract requirements? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

4.4 Did the Waiver Agent use the correct care setting statuses? (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? (Multi-Year Citation)

◯ Yes ◯ No ◯ N/A

Comments:

5.8. Did the record reflect the Supports Coordinator (SC) gave the participant the opportunity to achieve and maintain independence and self-direction, which includes Self-Determination (SD) and the opportunity to direct and engage in the service planning process? (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? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

6.6: Did the Supports Coordinator (SC) provide the participant the opportunity to manage environmental and home-based risks throughout the care planning and service delivery as required by MDHHS and the contract? (Recommendation)

◯ 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:

6.8. Was the information in the assessment consistent, providing a clear picture of the participant's strengths, needs, and abilities, and contained relevant information and explanations? (New 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:

7.3. Did the record validate the Clinical Supports Coordinator reviewed the medications and sought resolution for an identified issue(s)? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

7.5. Did the Medication Record identify the participant's known pharmaceutical, environmental, and food allergies, including allergic reactions or identify the participant had no known allergies? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

7.6. Did the Supports Coordinator (SC) assess/document how the participant's medications were managed? (New 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:

8.1. Did the Supports Coordinator (SC) develop, evaluate, and update the Person-Centered Service Plans (PCSP) as required by Federal Regulations and the MDHHS contract? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

8.3. Did the Supports Coordinator ensure the participant was provided education and information to make informed decisions regarding personal choice(s)? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

8.4. Did the Person-Centered Service Plan (PCSP) identify the participant's issues that are triggered and require continued monitoring by the Supports Coordinator (SC)? (New Citation)

◯ 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:

8.7: Did the services and supports on the Person-Centered Service Plan (PCSP) include the details of the intervention (provider name, type of provider, type of service, service amount/frequency/duration)? (Recommendation)

◯ 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? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

8.13. Did the participant approve the Person-Centered Service Plan (PCSP)? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

8.14: Did the participant receive a copy of their Person-Centered Service Plan (PCSP) as required by Federal Regulations and the MDHHS contract? If no, were they offered a copy and declined? (Recommendation)

◯ Yes ◯ No ◯ N/A

Comments:

9.2: Is the Service Summary accurate and complete? (Recommendation)

◯ Yes ◯ No ◯ N/A

Comments:

9.4. Did the record validate the participant was offered all appropriate services? (New Citation)

◯ 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? (New Citation)

◯ Yes ◯ No ◯ N/A

Comments:

9.6: Did the authorized MI Choice Program services meet requirements as defined in the MI Choice chapter of the Medicaid Provider Manual? (Recommendation)

◯ 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:

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? (Multi-Year 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:

11.3. Did the Supports Coordinator (SC) ensure service delivery in accordance with the PCSP, including the use of the participant's back-up plan or an out-of-network provider, as required by Federal Regulations and the MDHHS contract? (New 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? (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: _____