Michigan Public Health Institute

Quality Assurance Review Application

Request for Proposals

Appendix B

Issued By

Michigan Public Health Institute

RFP Identifier: MPHI-QAR-001

Issued on: July 22, 2019

MI Choice Clinical Quality Assurance Review
FY 2019 CQAR Record Review Tool

Level of Care Determination (I.B.2.a)

Level of Care Determination (I.B.2.a)
1. Was a Level of Care Determination, including the Nursing Facility Level of Care determination, in CHAMPS prior to initial enrollment? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
2. Was a Level of Care Determination, including the Nursing Facility Level of Care determination, in CHAMPS prior to re-enrollment? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
3. Was the Level of Care Determination in CHAMPS valid throughout the review year? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
4. Did the Waiver Agent adopt the Level of Care Determination? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
5. Was the Level of Care Determination conducted by a qualified professional? (Performance Measure 2 and Performance Measure 7) ☐ Yes ☐ No ☐ NA
6. Did the Waiver Agent validate the accuracy of the Level of Care Determination enrollment door? (Performance Measure 2) ☐ Yes ☐ No ☐ NA

Freedom of Choice (I.B.2.b)

Freedom of Choice (I.B.2.b)
1. Is there a Freedom of Choice form in the record? (Performance Measure 2) ☐ Yes ☐ No ☐ NA

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Freedom of Choice (I.B.2.b)
2. Does the Freedom of Choice form indicate that the participant chose the MI Choice program? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
3. Is the Freedom of Choice form dated prior to, or on, the date of enrollment? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
4. If the participant was unable to sign, did the Waiver Agent attempt to obtain the Representative's signature? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
5. Is the participant's/representative's signature on the form? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
6. Is the participant's/representative's signature dated? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
7. Is the Supports Coordinator's or other qualified professional's signature on the form? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
8. Is the Supports Coordinator's or other qualified professional's signature dated? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
9. Is the Freedom of Choice form dated on or prior to the date of re-enrollment, or dated within 7 days of a nursing facility discharge? (Performance Measure 2) ☐ Yes ☐ No ☐ NA

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Release of Information (V.F.2.a)

Release of Information (V.F.2.a)
1. Is there a valid Release of Information form in the record for the review period? ☐ Yes ☐ No ☐ NA 2. Does it give authorization for one year or less from the date it was signed? ☐ Yes ☐ No ☐ NA
3. Did the participant sign and date the Release of Information form? If not, is there an explanation of why the participant could not sign for him or herself? ☐ Yes ☐ No ☐ NA 4. Did a legal guardian or other designated person sign and date the Release of Information form? ☐ Yes ☐ No ☐ NA
5. Did the Supports Coordinator sign and date the Release of Information? ☐ Yes ☐ No ☐ NA 6. Did this signature include their credentials? ☐ Yes ☐ No ☐ NA

Status (I.B.2.e)

Status (I.B.2.e)
1. Were the correct program statuses used? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
2. Were the MI Choice Program enrollment date(s) in the record? (Performance Measure 2) ☐ Yes ☐ No ☐ NA

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Status (I.B.2.e)
3. Were the MI Choice Program disenrollment date(s) in the record? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
4. Did the participant have any eligibility changes during the review year? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
5. Were the correct care setting statuses used? (Performance Measure 2) ☐ Yes ☐ No ☐ NA
6. Were the enrollment and/or dis-enrollment date(s) in CHAMPS consistent with the MI Choice status in the Waiver Agent's information technology system? (Performance Measure 2) ☐ Yes ☐ No ☐ NA

Pre-Planning

Pre-Planning
1. Did the Supports Coordinator contact the participant/guardian prior to assessments and planning meetings to ensure the date(s), time(s) and location(s) were convenient for the participant/guardian? (II.A.2.b; Performance Measure 18) ☐ Yes ☐ No ☐ NA
2. Did the Supports Coordinator inform the participant of the right to choose and include allies in planning meetings and provide the support necessary to ensure that the allies were included? (II.A.2.b; Performance Measure 18) ☐ Yes ☐ No ☐ NA

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Pre-Planning

3. If the participant has a legal guardian, does the Waiver Agency record contain a copy of the guardianship order?
   - ☐ Yes
   - ☐ No
   - ☐ NA
4. Did the Supports Coordinator ensure that less obtrusive measures were not available or appropriate prior to securing guardianship during the review year?
   - ☐ Yes
   - ☐ No
   - ☐ NA

5. Did the Supports Coordinator provide the participant/guardian a copy of the MI Choice Waiver Participant Handbook?
   - ☐ Yes
   - ☐ No
   - ☐ NA

6. When the participant first enrolled, did the Supports Coordinator inform the participant of their rights and responsibilities and how to access those rights? (V.A.2.a)
   - ☐ Yes
   - ☐ No
   - ☐ NA
7. Did the Supports Coordinator provide this information again at least annually?
   - ☐ Yes
   - ☐ No
   - ☐ NA

8. When the participant first enrolled, did the Supports Coordinator inform the participant/guardian of the need to report critical incidents? (V.A.2.a)
   - ☐ Yes
   - ☐ No
   - ☐ NA
9. Did the Supports Coordinator provide this information again at least annually?
   - ☐ Yes
   - ☐ No
   - ☐ NA

10. Did the Supports Coordinator give the participant the opportunity to achieve and maintain independence and self-direction? (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA

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Pre-Planning

11. Did the Supports Coordinator consider and respect the participant's cultural background by providing information in plain language? (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
12. Did the Supports Coordinator provide information in a manner that is accessible to participants with disabilities? (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
13. Did the Supports Coordinator provide information in a manner that is accessible to participants who have limited English proficiency? (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
14. If the participant had a sensory and/or communication limitation, did the Supports Coordinator consider those limitations and provide accommodations for the planning process as preferred by the participant/guardian? (II.A.2.d; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
15. Did the Supports Coordinator give the participant/guardian the opportunity to direct and engage in the service planning process? (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
16. Did the Supports Coordinator provide the participant with information about service providers? (II.A.2.a.i (2); Performance Measure 18 and Performance Measure 22)
    - ☐ Yes
    - ☐ No
    - ☐ NA
17. Did the Supports Coordinator provide the participant/guardian the opportunity to manage risk? This includes risk in safety considerations, health care needs, personal choices, and social needs. (II.A.2.a; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA

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Assessment

Assessment
1. Did the Waiver Agent use a Registered Nurse and Licensed Social Worker team approach to complete the Initial Assessment? (I.B.2.i; Performance Measure 2) ☐ Yes ☐ No ☐ NA 2. Did the participant require Supports Coordination Services and an additional MI Choice service based on the Initial Assessment? (I.B.2.j; Performance Measure 2) ☐ Yes ☐ No ☐ NA 3. Did the Initial Assessment identify the participant's strengths and preferences? (I.B.2.j; Performance Measure 2) ☐ Yes ☐ No ☐ NA
4. Did the Supports Coordinator complete a Re-Assessment within 90 days following the Initial Assessment? (II.B.2.i) ☐ Yes ☐ No ☐ NA 5. Did the Supports Coordinator complete a Re-Assessment at least annually thereafter? (II.B.2.i) ☐ Yes ☐ No ☐ NA
6. Was the frequency of Re-Assessments consistent with the participant's choices, health status, physical needs, mental health needs, and informal network? (II.B.2.i) ☐ Yes ☐ No ☐ NA
7. Did the participant meet MI Choice Waiver Program eligibility in the Re-Assessment(s)? (II.B.2.j) ☐ Yes ☐ No ☐ NA

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Assessment

8. Did the Supports Coordinator assess the participant's risks? (IV.C.2.a)
   - ☐ Yes
   - ☐ No
   - ☐ NA
9. Did the Supports Coordinator provide education related to choices that may increase the participant's risks?
   - ☐ Yes
   - ☐ No
   - ☐ NA
10. Did the Supports Coordinator offer modifications to promote safety and independence?
   - ☐ Yes
   - ☐ No
   - ☐ NA

11. If the Supports Coordinator identified the use of restraints or seclusion, did the Supports Coordinator evaluate, address, and offer alternatives to the use of restraints or seclusion? (IV.D.2.a)
   - ☐ Yes
   - ☐ No
   - ☐ NA

12. Overall, was the information in the record consistent and relevant, without being confusing or contradictory? (This includes the data fields, coding, and comments on the assessments, Person-Centered Service Plan, contact notes, status tables, and service authorizations.) (I.B.2.j, II.B.2.j; Performance Measure 2)
   - ☐ Yes
   - ☐ No
   - ☐ NA
13. Did it provide a clear picture of the individual's strengths, needs and abilities?
   - ☐ Yes
   - ☐ No
   - ☐ NA
14. Did it show whether the interventions in the Person-Centered Service Plan were helping the participant to meet their goals?
   - ☐ Yes
   - ☐ No
   - ☐ NA
15. Did the comment sections contain relevant information that explained assessed issues and needs? (I.B.2.j, II.B.2.j; Performance Measure 2)
   - ☐ Yes
   - ☐ No
   - ☐ NA

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Assessment
16. Did the Registered Nurse and Licensed Social Worker collaborate, demonstrating a team approach? (II.A.2.j, II.B.2.j; Performance Measure 18) ☐ Yes ☐ No ☐ NA

Medication Record (IV.E.2.a)

Medication Record (IV.E.2.a)
1. Did the Medication Record include all prescribed medications? ☐ Yes ☐ No ☐ NA 2. Did the Medication Record include the name, prescribing physician, purpose, strength/dose, frequency, and route for all medications? ☐ Yes ☐ No ☐ NA
3. Did the Medication Record include all over-the-counter medications? ☐ Yes ☐ No ☐ NA
4. Did the Medication Record identify the pharmacy/pharmacies the participant used? ☐ Yes ☐ No ☐ NA
5. Did the Medication Record identify the participant's known allergies? ☐ Yes ☐ No ☐ NA
6. Did the Supports Coordinator assess how the participant's medications were managed ☐ Yes ☐ No ☐ NA 7. Did the Supports Coordinator address issues the participant had with medication regimen compliance? ☐ Yes ☐ No ☐ NA

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Medication Record (IV.E.2.a)
8. Did the Supports Coordinator act to reduce the risk of medication mismanagement? ☐ Yes ☐ No ☐ NA

Person-Centered Service Plan

Person-Centered Service Plan
1. Was the initial Person-Centered Service Plan developed within 10 business days of MI Choice Waiver Program enrollment? (II.A.2.i (1); Performance Measure 1 and Performance Measure 18) ☐ Yes ☐ No ☐ NA
2. Did the Registered Nurse and Licensed Social Worker sign and date the initial Person-Centered Service Plan? (II.A.2. i; Performance Measure 18) ☐ Yes ☐ No ☐ NA
3. Did the Person-Centered Service Plan contain an acknowledgement that the participant/guardian chose the setting in which they resided? (II.A.2.b (1); Performance Measure 18) ☐ Yes ☐ No ☐ NA
4. Did the Person-Centered Service Plan contain the participant's strengths and preferences? (II.A.2.i; Performance Measure 18) ☐ Yes ☐ No ☐ NA
5. Did the Person-Centered Service Plan include the services and supports that were important to the participant/guardian? (II.A.2.b (1); Performance Measure 18) ☐ Yes ☐ No ☐ NA
6. Did the Person-Centered Service Plan include the participant/guardian's preferences for service delivery? (II.A.2.b (1); Performance Measure 17 and Performance Measure 18) ☐ Yes ☐ No ☐ NA
7. Did the participant/guardian make informed choices? (IV.A.2.b; CMS Performance Measure 16) ☐ Yes ☐ No ☐ NA

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Person-Centered Service Plan

8. Did the Supports Coordinator identify the participant's health and welfare issues? (IV.A.2.b CMS Performance Measure 16)
   - ☐ Yes
   - ☐ No
   - ☐ NA
9. Did the Supports Coordinator consider those risks throughout care planning and waiver service delivery?
   - ☐ Yes
   - ☐ No
   - ☐ NA
10. Did the Supports Coordinator consider those risks throughout care planning and non-waiver service delivery?
    - ☐ Yes
    - ☐ No
    - ☐ NA

11. Did the Supports Coordinator list a goal for each need and risk identified as important to the participant/guardian? (II.A.2.b (1); Performance Measure 17 and Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA

12. Did the Person-Centered Service Plan list the participant's needs and risk factors?
    - ☐ Yes
    - ☐ No
    - ☐ NA
13. Did the Person-Centered Service Plan describe the measures in place to minimize risk factors, including back-up plans and strategies when needed? (II.A.2.i; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA

14. Did the Supports Coordinator communicate the participant/guardian's preferences about health and welfare choices to service providers? (IV.A.2.e)
    - ☐ Yes
    - ☐ No
    - ☐ NA
15. Did the Supports Coordinator help service providers to honor the participant/guardian's choice? (IV.A.2.e)
    - ☐ Yes
    - ☐ No
    - ☐ NA

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Person-Centered Service Plan

16. Did the Person-Centered Service Plan list services and supports that helped the participant achieve goals? (II.A.2.i; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
17. Did these services and supports include both waiver and non-waiver services and supports when applicable?
    - ☐ Yes
    - ☐ No
    - ☐ NA
18. Did these services and supports include type, amount, frequency, and duration?
    - ☐ Yes
    - ☐ No
    - ☐ NA
19. Did the Person-Centered Service Plan list the providers of these services and supports, including natural and informal supports?
    - ☐ Yes
    - ☐ No
    - ☐ NA
20. Did the Person-Centered Service Plan include an acknowledgement that informal supports agreed to provide uncompensated services and supports? (II.A.2.i; Performance Measure 18)
    - ☐ Yes
    - ☐ No
    - ☐ NA
21. If the participant lived in a provider-owned or -controlled setting, did the Supports Coordinator contact and collaborate with the provider-owned or controlled setting? (II.B.2.f.i)
    - ☐ Yes
    - ☐ No
    - ☐ NA
22. If the participant received skilled care, did the Supports Coordinator contact the skilled care provider? (II.B.2.a.i)
    - ☐ Yes
    - ☐ No
    - ☐ NA
23. Did the Supports Coordinator collaborate with the skilled care provider to develop the Person-Centered Service Plan?
    - ☐ Yes
    - ☐ No
    - ☐ NA

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Person-Centered Service Plan

24. If the participant received hospice or palliative care, did the Supports Coordinator contact the hospice or palliative care provider? (II.B.2.a.i)
    - ☐ Yes
    - ☐ No
    - ☐ NA
25. Did the Supports Coordinator collaborate with the hospice or palliative care provider to develop the Person-Centered Service Plan?
    - ☐ Yes
    - ☐ No
    - ☐ NA

26. Did the Person-Centered Service Plan include outcome evaluations or statements for each goal? (II.A.2.i) Performance Measure 18
    - ☐ Yes
    - ☐ No
    - ☐ NA
27. Did the Person-Centered Service Plan include interventions to address each issue, need, concern, and risk?
    - ☐ Yes
    - ☐ No
    - ☐ NA

28. Did the Supports Coordinator update the Person-Centered Service Plan within 90 days following the Initial Assessment? (II.B.2.f) Performance Measure 19
    - ☐ Yes
    - ☐ No
    - ☐ NA

29. Did the Supports Coordinator update the Person-Centered Service Plan within 180-day intervals? (II.B.2.f; Performance Measure 19)
    - ☐ Yes
    - ☐ No
    - ☐ NA
30. If the participant preferred more frequent updates, did the Supports Coordinator update the Person-Centered Service Plan in the timeframe the participant preferred?
    - ☐ Yes
    - ☐ No
    - ☐ NA
31. If the participant had a change in status that required a more frequent update to the Person-Centered Service Plan, did the Supports Coordinator update the Person-Centered Service Plan as required by this change in status?
    - ☐ Yes
    - ☐ No
    - ☐ NA

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Person-Centered Service Plan
32. Did the participant's Person-Centered Service Plan effectively meet the participant's needs? (II.B.2.f) ☐ Yes ☐ No ☐ NA
33. If the participant requested that the Supports Coordinator evaluate the Person-Centered Service Plan, did the Supports Coordinator evaluate the Person-Centered Service Plan? (II.B.2.f; Performance Measure 19) ☐ Yes ☐ No ☐ NA
34. If the Supports Coordinator identified a change in the participant's needs, did the Supports Coordinator update the Person-Centered Service Plan to reflect this change in needs? (II.B.2.f; Performance Measure 19) ☐ Yes ☐ No ☐ NA
35. Did the Person-Centered Service Plan show the participant achieved or made progress toward achieving goals? If not, did the Person-Centered Service Plan explain the barriers to achieving goals? (II.B.2.g; Performance Measure 19) ☐ Yes ☐ No ☐ NA
36. Did the Supports Coordinator include outcome evaluations for each goal in the Person-Centered Service Plan within 90 days after the Initial Assessment? (II.B.2.g; Performance Measure 19) ☐ Yes ☐ No ☐ NA 37. Did the Supports Coordinator perform outcome evaluations for each goal at least every 180 days thereafter? (II.B.2.g; Performance Measure 19) ☐ Yes ☐ No ☐ NA
38. Is the person responsible for monitoring the Person-Centered Service Plan identified in the plan? (II.A.2.i; Performance Measure 18) ☐ Yes ☐ No ☐ NA

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Person-Centered Service Plan
39. Did the participant or guardian approve the participant's Person-Centered Service Plan? (Verbally, and then followed by a written authorization.) (II.A.2.i; Performance Measure 18) ☐ Yes ☐ No ☐ NA
40. Did the participant/guardian receive a copy of their Person-Centered Service Plan? If no, were they offered a copy and declined? (II.A.2.l; Performance Measure 18) ☐ Yes ☐ No ☐ NA
41. Was the Person-Centered Service Plan understandable, written in plain language, and offered in a manner that is accessible to the participant? (II.A.2.l; Performance Measure 18) ☐ Yes ☐ No ☐ NA

MI Choice Services

MI Choice Services
1. Are the authorized MI Choice services consistent with the participant's needs? (II.A.2.c; Performance Measure 15 and Performance Measure 18) ☐ Yes ☐ No ☐ NA
2. Did the Service Summary contain accurate and complete information? (II.A.2.c; Performance Measure 15 and Performance Measure 18) ☐ Yes ☐ No ☐ NA
3. Did the participant receive at least one MI Choice service on a continual basis in addition to Supports Coordination? If not, did the Waiver Agent make an effort to secure these services? (II.A.2.c; Performance Measure 15, Performance Measure 18, Performance Measure 20, and Performance Measure 38) ☐ Yes ☐ No ☐ NA
4. Did the Supports Coordinator offer the participant/guardian all appropriate MI Choice services? (II.A.2.g; Performance Measure 18 and Performance Measure 21) ☐ Yes ☐ No ☐ NA

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MI Choice Services

5. Did the Supports Coordinator authorize a change in MI Choice Service(s) within 10 working days, or provide the participant with appropriate alternatives? (II.B.2.f)
   - ☐ Yes
   - ☐ No
   - ☐ NA

7. Did the authorized MI Choice services meet MI Choice service standard requirements? (II.A.2.c; Performance Measure 15 and Performance Measure 18)
   - ☐ Yes
   - ☐ No
   - ☐ NA

a Adult Day Health
   - ☐ Met
   - ☐ Not Met
   - ☐ NA

b Chore Services
   - ☐ Met
   - ☐ Not Met
   - ☐ NA

c Community Living Support
   - ☐ Met
   - ☐ Not Met
   - ☐ NA

i Do all assigned Self Determination workers have Self Determination Training records in the participant record?
   - ☐ Yes
   - ☐ No
   - ☐ NA

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MI Choice Services

d Community Health Worker

- ☐ Met
- ☐ Not Met
- ☐ NA

i Did the Community Health Worker visit the participant in their home within 3 days of hospital or facility discharge? (FY 2019 MI Choice Contract, Attachment H, pg. 22-23)

- ☐ Yes
- ☐ No
- ☐ NA

ii Did the Community Health Worker visit the participant in their home within 30 days of hospital or facility discharge? (FY 2019 MI Choice Contract, Attachment H, pg. 22-23)

- ☐ Yes
- ☐ No
- ☐ NA

iii Did the Community Health Worker use this visit to identify if follow-up actions were resolved or if additional follow-up was needed?

- ☐ Yes
- ☐ No
- ☐ NA

iv Did the Community Health Worker report any medication issues or discrepancies to the Supports Coordinator? (FY 2019 MI Choice Contract, Attachment H, pg. 22-23)

- ☐ Yes
- ☐ No
- ☐ NA

v Did the Community Health Worker collaborate with the Supports Coordinator throughout service provision? (FY 2019 MI Choice Contract, Attachment H, pg. 22-23)

- ☐ Yes
- ☐ No
- ☐ NA

e Community Transportation Services

- ☐ Met
- ☐ Not Met
- ☐ NA

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MI Choice Services

f Counseling Services

- ☐ Met
- ☐ Not Met
- ☐ NA

i Did the counseling provider have a case conference with the Supports Coordinator at least once every 6 weeks? (FY 2019 MI Choice Contract, Attachment H, pg. 38)

- ☐ Yes
- ☐ No
- ☐ NA

g Environmental Accessibility Adaptations (Home Modifications)

- ☐ Met
- ☐ Not Met
- ☐ NA

i Did the Supports Coordinator verify that the work was complete and correct within 10 working days of completion of the home modification? (FY 2019 MI Choice Contract, Attachment H, pg. 40-42)

- ☐ Yes
- ☐ No
- ☐ NA

ii Did a local building inspector verify that the work satisfied applicable building codes within 10 working days of completion of the home modification? (FY 2019 MI Choice Contract, Attachment H, pg. 40-42)

- ☐ Yes
- ☐ No
- ☐ NA

iii Did the participant acknowledge that the work was acceptable within 10 working days of completion of the home modification? (FY 2019 MI Choice Contract, Attachment H, pg. 40-42)

- ☐ Yes
- ☐ No
- ☐ NA

h Fiscal Intermediary Services

- ☐ Met
- ☐ Not Met
- ☐ NA

i Goods and Services

- ☐ Met
- ☐ Not Met
- ☐ NA

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MI Choice Services

j Home Delivered Meals

- ☐ Met
- ☐ Not Met
- ☐ NA

k Nursing Services

- ☐ Met
- ☐ Not Met
- ☐ NA

i Was the nursing service authorized to prevent additional decline, illness or injury to the participant? (FY 2019 MI Choice Contract, Attachment H, pg. 56)

- ☐ Yes
- ☐ No
- ☐ NA

ii Did the Waiver Agent communicate with both the nurse providing nursing services and the participant's health care professional to assure the nursing needs of the participant were being addressed? (FY 2019 MI Choice Contract, Attachment H, pg. 56)

- ☐ Yes
- ☐ No
- ☐ NA

iii Did the participant meet at least one of the criteria for this service as defined in the FY 2019 MI Choice Contract, Attachment H, pg. 56?

- ☐ Yes
- ☐ No
- ☐ NA

iv Was the nursing service authorized for medication management for the participant? (FY 2019 MI Choice Contract, Attachment H, pg. 57)

- ☐ Yes
- ☐ No
- ☐ NA

v The participant did not receive MI Choice Private Duty Nursing services. (FY 2019 MI Choice Contract, Attachment H, pg. 65)

- ☐ Yes
- ☐ No
- ☐ NA

l Personal Emergency Response System

- ☐ Met
- ☐ Not Met
- ☐ NA

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MI Choice Services

m Private Duty Nursing/Respiratory Care

- ☐ Met
- ☐ Not Met
- ☐ NA

i Did the participant meet Medical Criteria I or II and Medical Criteria III? (FY 2019 MI Choice Contract, Attachment H, pg. 62)

- ☐ Yes
- ☐ No
- ☐ NA

ii Was there a physician order for the private duty nursing services authorized? (FY 2019 MI Choice Contract, Attachment H, pg. 62)

- ☐ Yes
- ☐ No
- ☐ NA

iii Did the participant record contain case notes sent by the service provider to update the Supports Coordinator on the condition of the participant? (FY 2019 MI Choice Contract, Attachment H, pg. 65)

- ☐ Yes
- ☐ No
- ☐ NA

iv Were these case notes sent monthly, or at least quarterly?

- ☐ Yes
- ☐ No
- ☐ NA

n Respite provided at the participant's home or the home of another

- ☐ Met
- ☐ Not Met
- ☐ NA

o Respite provided outside the home in a Medicaid-Certified or licensed group home or licensed nursing facility

- ☐ Met
- ☐ Not Met
- ☐ NA

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MI Choice Services

p Specialized Medical Equipment and Supplies
- ☐ Met
- ☐ Not Met
- ☐ NA

i Did the participant record contain a physician order for the liquid supplements? (FY 2019 MI Choice Contract, Attachment H, pg. 49 and 74)
- ☐ Yes
- ☐ No
- ☐ NA

ii Was the order for liquid nutritional supplements renewed every 6 months?
- ☐ Yes
- ☐ No
- ☐ NA

iii Did the participant record contained a physician order for the liquid meals? (FY 2019 MI Choice Contract, Attachment H, pg. 49)
- ☐ Yes
- ☐ No
- ☐ NA

iv Was the order for liquid meals renewed every 3 months?
- ☐ Yes
- ☐ No
- ☐ NA

q Supports Coordination
- ☐ Met
- ☐ Not Met
- ☐ NA

r Training
- ☐ Met
- ☐ Not Met
- ☐ NA

Linking and Coordinating (II.B.2.a)

Linking and Coordinating (II.B.2.a)

1. If the participant/guardian needed assistance with the Medicaid application or redetermination process, did the Waiver Agent provide assistance? (I.B.2.d) Performance Measure 2
   - ☐ Yes
   - ☐ No
   - ☐ NA

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Linking and Coordinating (II.B.2.a)

2. Did the Supports Coordinator assess the presence of existing non-waiver services and provide ongoing coordination and monitoring as preferred by the participant/guardian?
   - ☐ Yes
   - ☐ No
   - ☐ NA

3. If any non-waiver services applied to the participant's needs or goals, did the Supports Coordinator provide the participant/guardian with information about these services or resources as preferred by the participant/guardian?
   - ☐ Yes
   - ☐ No
   - ☐ NA

4. Did the Supports Coordinator link the participant to non-waiver services as preferred by the participant/guardian?
   - ☐ Yes
   - ☐ No
   - ☐ NA

5. If the participant experienced difficulty in securing non-waiver services, did the Supports Coordinator continue to assist them?
   - ☐ Yes
   - ☐ No
   - ☐ NA

6. Did the Supports Coordinator ensure proper and cost-effective use of resources?
   - ☐ Yes
   - ☐ No
   - ☐ NA

a J&B Medical Supply
   - ☐ Yes
   - ☐ No
   - ☐ NA

b Medical Treatment Providers (outpatient services, Visiting Physician Association, wound clinics, pain clinics, etc.)
   - ☐ Yes
   - ☐ No
   - ☐ NA

c Mental Health Services (CMH, private agency, mental health support groups, etc.)
   - ☐ Yes
   - ☐ No
   - ☐ NA

d Podiatry
   - ☐ Yes
   - ☐ No
   - ☐ NA

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Linking and Coordinating (II.B.2.a)
e Dental, Vision, and/or Hearing ☐ Yes ☐ No ☐ NA
f Veteran Administration Benefits ☐ Yes ☐ No ☐ NA
g State Programs (Food Assistance Program, and/or State Emergency Relief) ☐ Yes ☐ No ☐ NA
h Clinical Advocacy and Support Organizations (Multiple Sclerosis Society, Alzheimer's Disease Organizations, and/or Parkinson's Disease Organizations) ☐ Yes ☐ No ☐ NA
i Prescription Assistance and/or Medicare Medicaid Assistance Program ☐ Yes ☐ No ☐ NA
j Housing Coordination ☐ Yes ☐ No ☐ NA
k Community Agencies (Food Banks, Legal Aid, Salvation Army, United Way, Commission on Aging, Religious Organization, and/or Commission for the Blind) ☐ Yes ☐ No ☐ NA
l Other. Define. ☐ Yes ☐ No ☐ NA Definition and/or explanation:

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Follow-Up and Monitoring

Follow-Up and Monitoring
1. Did the Waiver Agent contact a newly-enrolled participant to ensure service delivery according to MDHHS Policy? (II.B.2.b; Performance Measure 20) ☐ Yes ☐ No ☐ NA
2. Did the Waiver Agent contact the participant/guardian/designated person for follow-up and monitoring as specified in the Person-Centered Service Plan and according to MDHHS Policy? (II.B.2.d) ☐ Yes ☐ No ☐ NA
3. Did the Waiver Agent ensure service delivery according to MDHHS Policy? (II.B.2.b; Performance Measure 20) ☐ Yes ☐ No ☐ NA
4. If there were no changes in the MI Choice service delivery, did the Waiver Agent ensure ongoing receipt and satisfaction of MI Choice services with the participant/guardian? (II.B.2.b; Performance Measure 20) ☐ Yes ☐ No ☐ NA
5. If the record identified a problem/concern with the service delivery of a MI Choice service, did the Waiver Agent take appropriate action to address the problem, including the use of the participant's back-up plan or an out-of-network provider? (II.B.2.b; Performance Measure 20) ☐ Yes ☐ No ☐ NA

Service Provider (II.B.2.e)

Service Provider (II.B.2.e)
1. If the participant experienced a health and welfare issue, did the service provider contact the Waiver Agent to inform them of the issue(s)? ☐ Yes ☐ No ☐ NA

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Service Provider (II.B.2.e)
2. Did a person other than the service provider(s) notify the Supports Coordinator of a health and welfare issue? ☐ Yes ☐ No ☐ NA

Contingency Plan (IV.F.2.a)

Contingency Plan (IV.F.2.a)
1. Did the record contain a complete and up-to-date contingency plan? (Performance Measure 30) ☐ Yes ☐ No ☐ NA
2. Did the participant/guardian receive a copy of the contingency plan? If no, were they offered a copy and declined? (Performance Measure 30) ☐ Yes ☐ No ☐ NA
3. Did the other allies included in the plan receive a copy of the contingency plan as preferred by the participant/guardian? (Performance Measure 30) ☐ Yes ☐ No ☐ NA
4. If the patient experienced an emergency, was the contingency plan implemented effectively? (IV.F.2.b) ☐ Yes ☐ No ☐ NA

Critical Incidents (IV.B.2.b, IV.B.2.b.i, IV.B.2.c, IV.B.2.d)

Critical Incidents (IV.B.2.b, IV.B.2.b.i, IV.B.2.c, IV.B.2.d)
1. Did the Supports Coordinator suspect that any critical incidents occurred? ☐ Yes ☐ No ☐ NA
2. Did the Supports Coordinator take appropriate action to address the incident with the participant/guardian? ☐ Yes ☐ No ☐ NA

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Critical Incidents (IV.B.2.b, IV.B.2.b.i, IV.B.2.c, IV.B.2.d)

3. Did the Supports Coordinator discuss methods to prevent further occurrence with the participant/guardian?
   - ☐ Yes
   - ☐ No
   - ☐ NA

4. What type of critical incident occurred? (Select all that apply)
   - ☐ Abuse/Physical
   - ☐ Abuse/Sexual
   - ☐ Abuse/Verbal
   - ☐ Exploitation
   - ☐ Hospital and Emergency Room visits within 30 days of a previous hospitalization due to abuse or neglect.
   - ☐ Hospitalization or emergency treatment resulting from a medication error.
   - ☐ Illegal activities in the home with the potential to cause serious harm or a major negative event.
   - ☐ Injuries requiring medical treatment resulting from abuse or neglect.
   - ☐ Neglect
   - ☐ Provider no-show for those participants who are bed-bound all day or have a critical need for services as indicated by a 1A, 1B, or 1C service need level.
   - ☐ Suicide attempts.
   - ☐ A suspicious or unexpected death that the Waiver Agent or other entity reports to law enforcement within 2 days and that is related to providing services supports, or caregiving.
   - ☐ Theft of anything.
   - ☐ Use of restraints, restrictive interventions, or seclusion.
   - ☐ Worker consuming drugs or alcohol on the job.
   - ☐ NA

5. Did the Waiver Agent enter, report, and provide updates to the critical incident portal within two business days of when the Waiver Agent became aware of the incident(s)? (IV.B.2.e)
   - ☐ Yes
   - ☐ No
   - ☐ NA

Adverse Benefit Determination (V.D.2.a)

1. Did the Waiver Agent provide the participant/guardian with an Adverse Benefit Determination?
   - ☐ Yes
   - ☐ No
   - ☐ NA

2. Was the Adverse Benefit Determination complete, and did it contain accurate information?
   - ☐ Yes
   - ☐ No
   - ☐ NA

3. Did the participant appeal the Waiver Agent's decision to deny access to, reduce, suspend, and/or terminate a MI Choice Service?
   - ☐ Yes
   - ☐ No
   - ☐ NA

4. Did the Waiver Agent adhere to MDHHS policy when the participant filed an appeal?
   - ☐ Yes
   - ☐ No
   - ☐ NA

5. Did the participant receive the Waiver Agent's decision and an Action Notice?
   - ☐ Yes
   - ☐ No
   - ☐ NA

Complaints and Grievances (V.E.2.b)

1. Did the participant/guardian initiate a complaint or grievance orally or in writing?
   - ☐ Yes
   - ☐ No (If no, this section is complete.)
   - ☐ NA

2. Was the Waiver Agent able to resolve the complaint or grievance at the Supports Coordinator level?
   - ☐ Yes
   - ☐ No
   - ☐ NA

3. Did the Waiver Agent adhere to MDHHS policy when the participant filed a formal grievance?
   - ☐ Yes
   - ☐ No
   - ☐ NA