**LTC Manual Chapter 23**

**Quality Assurance and Improvement**

The purpose of this chapter is to explain quality assurance and quality improvement (QA and QI) activities, processes, and expectations.

**Ask an Expert**

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### Background

##### Purpose

The purpose of this chapter is to outline QA/QI activities and responsibilities for Aging and Long-Term Support Administration (ALTSA), Home and Community Services (HCS) Division.

To provide quality, well-planned, efficient, and accountable home and community-based care is one of the central missions of ALTSA. The development of a Quality Assurance (QA) system is critical in accomplishing this mission. This QA system encompasses both financial and social services quality assurance/improvement and includes activities such as:

1. Quality assurance procedures that will enable ALTSA to evaluate and ensure its ongoing compliance with Federal Funding Participation (FFP) thus ensuring federal match for ALTSA programs, Centers for Medicaid and Medicare Services (CMS) protocols, Home and Community Based Service waiver requirements, and State and Federal law;
2. Gathering a consistent broad range of information to identify trends, strengths and areas for improvement across all programs;
3. Identifying training needs for quality improvement. Development of training is necessary to address trends at all levels – individual, local unit, regional/Area Agency on Aging (AAA), and statewide;
4. Identifying best practices within HCS and AAA operations with the purpose of sharing strategies across the state;
5. Collecting client feedback to determine satisfaction with the services;
6. Within the electronic QA Monitor Tool, assessing compliance with existing regulations, policies and standards;
7. Reviewing the overall quality of client cases, focusing on the quality and accuracy of the assessment, care plan, and determining whether issues identified in the case regarding quality of care are responded to in a timely manner;
8. Reviewing the level of care determinations to assure that clients require the care and services for which they have been authorized;
9. Confirming provider qualifications;
10. Verifying that mandatory referrals are being made;
11. Assuring that client services and payments for those services are appropriately authorized and paid; and
12. Assuring that clients are financially eligible for Long-Term Care (LTC) services.

##### Why is Quality Assurance and Quality Improvement Important

All staff are invested in ensuring that quality services are being provided to the clients served by the department. Looking at quality from a global perspective, the reasons we do quality work are to:

* Ensure that all services promote the health, safety, and self-determination of the people we serve; and
* Make sure that the department is accountable to the state and federal stakeholders who provide funding for the services provided to our clients.

So much of what HCS does is to help the client obtain appropriate quality services to maximize their independence, dignity, and quality of life. The client is the ultimate beneficiary of our quality assurance and quality improvement activities.

In addition, we are accountable to the state and federal governments. About half of every dollar that is spent on our state’s long-term services and supports programs is “matched” by the federal government. But, in order to get that match, ALTSA has to provide information to the federal government (CMS) to show that we are accountable for the funds we receive and that we are meeting their quality standards. CMS establishes quality standards for all states with regard to:

* waiver oversight
* client level of care assessments
* independence and choice
* person-centered client service plans
* client health and welfare
* provider qualifications, and
* financial accountability for the funds spent

In fact, if ALTSA cannot provide the evidence to CMS to show that we are meeting their quality standards, they could:

* Not approve of our waiver or state plan programs
* Not renew our existing programs
* Put a moratorium on waiver enrollments
* Withhold the federal match for services until compliance is achieved
* Impose financial penalties
* Require the state to hire an outside technical contractor to help develop compliance protocols and activities
* Take other actions as determined by the CMS Secretary

In addition to the federal compliance requirements, our state has developed additional quality standards based on important issues and priorities such as Skin Observation Protocol, nursing referrals, and client treatment questions.

##### Philosophy

Everyone is invested in quality – the goal of HCS has always been for HCS Headquarters (HQ), the Regions, and AAAs to work collaboratively toward quality assurance and improvement. Though a compliance review will always be required, the focus is moving to a more collaborative quality improvement process. The quality approaches and processes within this chapter support these goals and meet the state and federal monitoring requirements.

##### CMS Requirements

Much of the work that we do has a federal overlay. The Centers for Medicare and Medicaid Services (CMS) requires states to provide evidence of discovery, remediation, and continuous quality improvement by developing and reporting on one or more performance measures for each CMS prescribed assurance and sub-assurance. States work with CMS to define their own performance measures based on the CMS requirements.

CMS defines four functions of a quality improvement cycle. These functions are Design, Discovery, Remediation, and Improvement. In order to maintain our waivers, CMS requires evidence that these functions are being implemented in a quality improvement strategy.

1. Design **–** Design is the process for describing how monitoring will occur and how issues will be addressed when detected. It is the plan for how the state will proactively strive for quality by identifying and addressing areas for improvement.
2. Discovery **–** Discovery is the process of gathering data and information on service participants to determine if there is adequate access to services and supports; the services and supports are delivered as indicated in their plan of care; that health and welfare is achieved; only qualified providers are used; and payments are accurate. Both positive and negative issues are identified.
3. Remediation **–** Remediation is the process of correcting individual problems that are discovered during the discovery process. The federal standard of compliance is 100%. *This means that to reach the 100% required remediation,* ***ALL*** *identified QA findings must be addressed and resolved*. The evidence report must include how many problems were identified (i.e., those issues with less than 100% compliance), how and when each problem was corrected, and the outcome of each issue.
4. Improvement **–** Quality Improvement includes changes at a systemic level to increase proficiency and improve the outcome of issues that were identified.

### CMS Federal Assurances

To see how this all ties in together, the CMS Assurances, Sub-Assurances, and Performance Measures document is located at:[**http://adsaweb.dshs.wa.gov/hcs/QA/**](http://adsaweb.dshs.wa.gov/hcs/QA/)