# Adult Protective Services

The purpose of Chapter 23c is to outline Quality Assurance and Quality Improvement activities for the Adult Protective Services (APS) Division.

#### Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

APS QA Unit Office of the Assistant Secretary QA Team for APS

[APSQAUnit@dshs.wa.gov](mailto:APSQAUnit@dshs.wa.gov)

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## Quality Assurance Overview

A Quality Management System (QMS) is a commonsense approach of organizing the business and

support processes that affect the quality of regulatory and service delivery. While an individual is critical

to the success of the system, they are only one component. The success of any QMS relies upon clearly

documented policy and procedures, adequate training, review of the processes being used, and when

necessary, a plan for improvement.

The Aging and Long-Term Services Administration (ALTSA) QA unit is located within the Office of the

Assistant Secretary (OAS) and collaborates with the Quality Improvement (QI) Unit and Adult Protective

Services (APS).

The QA Unit’s purpose is to complete process reviews which provide data to show required standards

are met, to work collaboratively with the divisions, to act as an internal control, and to help identify

areas for improvement.

The APS QI Unit’s purpose is to examine processes within APS and identify areas to address system gaps.

The QI unit develops Proficiency Improvement Plans (PIPs) in response to the QA process reviews in

partnership with APS staff. Additionally, the QI unit leads the APS division in the development and

implementation of all statewide QI policies, processes, and procedures to assist in assuring division

compliance with all state and federal requirements, as well as agency and administration policies.

APS must comply with the following federal regulations and Revised Code of Washington (RCW)

chapters:

A. RCW 74.34

B. WAC 388-103

C. 42 U.S. CODE § 1396R (g)(1)(D)

D. 42 U.S. Code § 1395i-3 (g)(1)(D)

E. SOCIAL SECURITY ACT 1819(G)(2)(D)

F. SOCIAL SECURITY ACT 1919(G)(2)(D)

G. RCW 43.17.385 QUALITY MANAGEMENT, ACCOUNTABILITY, AND PERFORMANCE SYSTEM

H. RCW 74.39A.051 QUALITY IMPROVEMENT PRINCIPLES

I. CMS QUALITY MEASURES AND REPORTING MEMO:

1. SECTION 3 – 86% PROFICIENCY THRESHOLD AND PIP REQUIREMENT

2. SECTION 2 – INDIVIDUAL FINDING REMEDIATION REQUIREMENT

J. STRATEGIC PLAN

1. STRATEGIC GOAL #2: HONOR INDEPENDENCE, RIGHTS, HEALTH & SAFETY FOR VULNERABLE ADULTS LIVING IN

HOME- AND COMMUNITY-BASED SETTINGS.

2. STRATEGIC GOAL #4: IMPROVE QUALITY, ACCOUNTABILITY AND RESPONSIVENES

This document contains information about the QMS within APS related to QA process reviews and QI activities. The content is relevant to APS staff, external stakeholders, and anyone seeking to understand the APS QMS.

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs) began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool. Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2024 Quality Improvement Coordinators (QICs) began the work of supporting the continuous improvement process in central intake and the regions.

Timely completion of quality assurance activities helps protect the health and safety of clients and provides oversight of operations. Activities include completing QA reviews to ensure compliance with quality measures; data analysis to identify gaps in the processes being used based on QA review results; developing proficiency improvement plans and creating solutions using feedback from staff at all levels. Identified findings are addressed and improvement plans are developed and monitored to ensure continuous quality improvement. Through these functions, APS will obtain more predictable outcomes that ensure protection of adults who are vulnerable with consistent and timely investigations while offering protective services, supports and referrals.

## Statewide Quality Assurance Objectives

1. Analysis of external and internal issues that affect the quality of service delivery that is

relevant to the division’s purpose and its strategic plan;

2. Evaluating and ensuring ongoing compliance with State and Federal law;

3. Ensuring that policies and procedures are clearly documented, and information is available,

useable, and updated when needed;

4. Identifying areas in the process that need improvement and developing appropriate counter

measures to address areas of concern at all levels – individual, local unit, regional, and

statewide;

5. Completing QA process reviews that will assess compliance with existing regulations,

policies, and standards;

6. Gathering a consistent and broad range of information to identify trends, strengths, and

areas for improvement across the division;

7. Identifying best practices within APS with the purpose of sharing strategies across the state;

8. Developing Proficiency Improvement Plans (PIP) with the objective of continuously

improving current processes that affect the quality of service delivery and ensure the health

and safety of vulnerable adults;

9. Ensuring a continuous flow of communication between all levels of APS.

## HQ Quality Assurance Unit Process Overview

• QA process review occurs at the Office of the Assistant Secretary QA Unit staff level.

• The 12-month QA Activities and Schedule is available on the OAS QA for APS SharePoint site.

• Statistically significant samples are pulled for each regional area based on the number of

completed Investigations and Investigations Closed No APS that were processed for each region

in an annual time period.

• Statistically significant samples are pulled for screened-in intakes and screened-out intakes that

were processed by APS Central Intake within an annual time period.

• Statistically significant samples are pulled for all investigations closed statewide within an

annual time period.

• QA Review Entrance letters are sent at the start of each process review cycle.

• APS Central Intake and the Regions have 30 business days from receiving the initial QA

proficiency reports to complete the necessary remediations and to also submit change requests.

• APS Central Intake and the Regions then have 5 business days to complete remediation if

necessary for findings that were upheld by the change committee.

• An Exit Conference may be conducted via Microsoft Teams at the completion of the review,

following any decisions from the change committee.

• OAS QA Consultants(s) conduct a 30-day HQ QA review to document remediation.

• Issues identified in the 30-day HQ QA Review as not fully remediated must be completed

immediately by APS Designated Staff.

• OAS QA Consultants(s) complete the Final Report which is a summary of all QA findings.

• A Proficiency Improvement Plan (PIP) will need to be developed for QA questions designated by

APS Director and/or the Aging and Long-Term Support Administration (ALTSA) Assistant

Secretary.

## Part 1: Quality Assurance Process Reviews

### A. GENERAL GUIDELINES

Background

QA was developed for APS as part of ALTSA’s Quality Management System (QMS) to improve processes

within APS and to ensure guidelines for participation in federal programs are maintained.

Starting January 2016, Adult Protective Services (APS) Headquarters (HQ) Program Managers (HQ PMs)

began completing Quality Assurance (QA) process reviews and entering data into the QA Monitor Tool.

Additionally, in 2017 Field Supervisors and Subject Matter Experts (SME) began completing QA reviews in the QA Monitor Tool. In 2020 the QA unit was transitioned to the Office of the Assistant Secretary (OAS) and continues to work with APS leadership and staff to complete QA activities. In 2024 Quality

Improvement (QI) consultants began supporting APS in implementation of the QMS.

Timely completion of QA activities helps protect the health and safety of clients and provides oversight

of operations. Through the QMS system APS will obtain more predictable outcomes that ensure

protection of adults who are vulnerable with consistent and timely investigations while offering

protective services, supports, and referrals.

For information about each setting or program area reviewed by QA, see Appendix D: Resources and

Forms.

Procedure

1. QA Unit will:

a. Conduct required process reviews to determine compliance with standards, state law, APS

policy, and federal regulations.

b. Follow all procedures to ensure consistent QA process reviews.

c. Complete process reviews in a timely manner.

d. Monitor the APSQAUnit@dshs.wa.gov email box and respond to inquiries within 2 working

(business) days (WD).

e. Clearly communicate findings and trends.

Note: The purpose of findings is to demonstrate an identified gap between policy guidance and

what was found during the process review.

f. Always maintain professional and respectful conduct.

2. QI Unit will:

a. Participate in any collaborative training sessions with the QA unit.

b. Assist with facilitating discussions with APS staff when process questions arise.

c. Monitor the ImproveAPS@dshs.wa.gov email box and respond to all inquiries within 2 WD.

d. Clearly communicate information.

e. Always maintain professional and respectful communication.

3. Region/central intake will:

a. Maintain one point of contact within the region or central intake for QA information and work

directly with the QI team. This is known as the Designated Staff (DS).

b. Enter all new staff with appropriate area and permissions into the QA Monitor application

(QAM).

c. Inactivate any staff within their respective area in QAM.

d. Notify Program Integrity (PI) Unit Manager of new hires and start dates.

e. Notify QA Unit Manager of any position changes requiring permissions changes to QAM.

Definition of Roles within the QA Unit

1. ALTSA QA Unit Manager

a. Recruits, hires, and ensures that new QA staff are trained.

b. Supervises and provides oversight to the QA Unit to ensures all processes and procedures are

followed and QA reviews are completed as required.

c. Performs regular spot checks of QA Consultant work for quality, consistency, and interrater

reliability.

d. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.

e. Assures the statistical relevance for all sampling and sample methodology and determines

samples sizes required.

f. Ensures QA staff maintain a working knowledge of all relevant policy.

g. Requests clarification from APS and ALTSA leadership as needed.

h. Maintains the QA SharePoint site.

i. Maintains the QA Monitor Tool.

i. Provides updates on QA Questions, No Responses, and review types based on changes to the

review process.

ii. Ensures trainings are available related to use of the QA Monitor Tool.

iii. Coordinates with Management Services Division (MSD) to repair bugs, create reports, or

work on issues as they arise.

2. Process Review Lead

a. The Process Review Lead (QA Lead) is the QA Consultant assigned to coordinate the process

review and all associated tasks to ensure completion.

b. Creates and distributes statistically significant and accurate samples.

c. Ensures all information and files are available for the process review, including updated reports,

updated question documents, information sheets, required files, and any other information

needed for the review.

d. Coordinates information requests to or from the program to be sure all questions and data

requests for the review are addressed. Tracks responses to ensure any required updates to

documents and processes are complete.

e. Ensures all QA reviews are entered and closed correctly during reviews, at the end of the review,

and at the end of the calendar year to validate reviews are completed in the QA Monitor Tool.

f. Creates or runs required reports to ensure historical records are available.

3. QA Consultant

a. Is a member of the QA Unit who coordinates and completes QA process reviews.

b. Completes process reviews in the manner prescribed in the instruction documents, in this

chapter, and in documents produced through the question document review process.

c. Works within the unit to ensure all work is completed in a professional and collaborative

manner.

4. ALTSA Management Analyst (MA)

a. Is a member of the ALTSA QMS who reports directly to the ALTSA Senior QA Administrator.

b. Provides QA and APS QI Coordinators (QICs) data analysis one WD prior to the exit conference

and two WD after initial proficiency reports are finalized.

c. Collaborates and consults with QA and QI when reviewing data.

d. Provides Ad Hoc data analysis and reports as requested by agreed deadlines.

e. Documents potential enhancements to QA reports throughout the year.

f. Work with the QA Monitor Development Team to correct issues with QA reports, suggest

improvements, and test changes to the QA tool or reports.

Definition of Roles within the QI Unit

1. APS Program Integrity Unit Manager

a. Supervises and provides oversight to the QI Unit to ensure all processes and procedures are

followed and QI activities are completed as required.

b. Recruits, hires, and ensures that new QI staff are trained.

c. Ensures QI staff demonstrate a working knowledge of this policy.

d. Conducts supervisory reviews of QI staff work to ensure policies and procedures are followed.

e. Requests clarification from APS leadership as needed.

f. Performs regular spot checks of QIC work for quality, consistency, and accuracy.

g. Assists the unit in completion of tasks to ensure work is completed timely and efficiently.

h. Distributes QA Process Review result reports to the Regional Administrators (RAs) and Program

Managers (PMs), following both the initial proficiency reports, as well as the final statewide exit

conference.

i. Present overview of QA/QI in collaboration with the QA Unit Manager, coordinated with the

training unit.

j. Maintains the QI SharePoint site.

k. Ensures all APS staff have access to QIC Central Resources.

l. Collaborates with APS leadership, policy, and statewide and regional trainers on QI activities.

m. Coordinates quarterly program meetings with the following units:

i. Policy – Send the invite to the Senior Policy Advisor.

ii. Training – Send the invite to the Training Unit Manager.

2. QI Program Lead

a. The Program Lead is the QIC assigned to coordinate all QI activities for the assigned program.

This includes but is not limited to QA process reviews response, including data analysis, change

requests, root cause analysis, and PIP development, as well as associated tasks to ensure

completion and ongoing monitoring. The lead is responsible for the success of all QI activities.

b. Supports, coordinates creation, and delivery of any QI driven trainings related to PIP activities

and form updates in cooperation with appropriate APS staff.

c. Presents QI Overview at program specific trainings, coordinated with the training unit.

d. Coordinates trainings for QI team members (i.e., needed QI checks, etc.).

e. Responds to all communications related to the assigned program received via the

ImproveAPS@dshs.wa.gov email inbox.

f. Ensures all QI monitoring checks are entered and closed per the process defined in the section

labelled 'Thirty Day Reviews.’

g. Lead will coordinate QI activities with their Co-Lead.

3. QI Program Co-Lead

a. Supports the QI Lead in completing program related QI activities.

b. If the QI Lead is unavailable, the Co-Lead will take additional Lead responsibilities as needed.

i. If what is needed is unclear, consult with the Unit Manager.

c. Provide technical support, including note taking, during any QI provided in-services and

presentations.

d. Co-Lead will coordinate QI activities with the QI Program Lead.

4. QI Coordinator

a. Is a member of the QI Unit who coordinates and completes QI activities.

b. Works within the unit to ensure all work is completed in a professional and collaborative

manner.

### B. PROCESS REVIEW SCHEDULE

Background

ALTSA QA maintains a 12-month QA Process Review Schedule, which runs January through December.

The schedule is available on the OAS QA for APS SharePoint site.

QA reviews are entered into the QA Monitor Tool or SharePoint Forms by QA or as a check by QI.

Reviews in QA Monitor must be closed and completed before the system lock-out in December when

updates are processed for the next review cycle. This includes adding necessary 30-Day reviews and

overturning findings when required. When reviews are not fully closed by the end of the calendar year,

they are locked in place and remain in the QA Monitor as open reviews with no way to close them. This

creates a layer of complexity that interferes with the functionality and ease of use of the system.

Procedure

The QA Unit Manager will publish a Management Bulletin (MB) at the beginning of each year to update

the process review schedule. If the dates or the number of reviews change after the original release,

staff will be notified, and the OAS QA for APS SharePoint site will be updated.

The Process Review Schedule includes key information, such as:

1. Each process review area being completed for the year.

2. Review dates: QA team trainings, entrance dates, and file review dates.

3. Dates the initial proficiencies will be provided to QI.

4. Change request and remediation due dates.

5. Change Request Committee (CRC) dates.

6. Exit conference dates.

7. PIP due dates.

QA Unit Manager Responsibility

1. Creates QA schedule.

2. Creates and submits the annual MB to the APS Policy unit for publication to provide APS with the

updated schedule and process review information.

3. Ensure training for new QA staff occurs.

4. Ensures QA staff demonstrate a working knowledge of this policy.

5. Conducts end of year review verifications to ensure staff are following the policy.

6. Assures that weekly updates are sent for posting when changes to the schedule are required.

PIP due dates

Program Integrity Unit Manager Responsibility

1. Review QA schedule.

2. Ensure appropriate staff are made aware of required dates and scheduled meetings.

3. Refer questions to QA Unit Manager as they arise.

Adult Protective Services Responsibility

4. Review QA schedule.

5. Ensure appropriate staff are made aware of required dates and scheduled meetings.

6. Refer questions to QA Unit Manager as they arise.

### C. QA QUESTION DOCUMENT REVIEW

Background

QA is responsible to complete process reviews using specific questions developed to ensure we are

meeting federal, state, and ALTSA leadership guidelines. The questions are reviewed and updated with input from APS Policy, Training, QI, and other subject matters experts. The questions are approved by

the APS Director.

Questions are updated based on current policies, procedures, the DSHS and ALTSA Strategic Plans,

federal legislation, federal requirements for State Plans, Waivers, and Home and Community-Based

setting rules, state legislation, current issues the division is experiencing, or in response to external

audits or litigation.

How QA reviews each of the questions is developed by the QA Unit with input from subject matter

experts (SMEs) and feedback from staff. This process is key to providing the opportunity for all staff to

provide input and ensure QA has as much information as possible to complete the review accurately and

efficiently.

QA data is tracked and may be reported to federal partners to provide evidence of compliance with

Medicare and Medicaid programs. The information gathered from QA process reviews is also intended

to assist the division with process improvement activities, act as an internal control, as well as maintain

compliance with applicable laws and policies

All current QA question documents are located on the QA SharePoint site and are available by

contacting QA at [APSQAUnit@dshs.wa.gov](mailto:APSQAUnit@dshs.wa.gov).

Procedure

1. Documents are reviewed, updated, and revised as changes are required.

2. The QA Unit Manager will facilitate communication with policy, training, area specific SMEs, and

other designated staff to review and discuss QA questions. All sections of the documents may be

reviewed and revised.

3. Once final drafts are completed, significant changes to questions or proficiency expectations are

reviewed and approved by the APS Director.

4. When MBs or new policies are published, QA will conduct reviews to that standard on the date the

MB or policy is effective.

5. QA question materials to be used for the year are published to the How to Review SharePoint Page.

Documents and links are also provided in the QA Schedule MB.

QA Unit Manager Responsibility

1. Outlines required changes with the APS Director to obtain final approval.

2. Ensure training for new QA staff occurs.

3. Ensures QA staff demonstrate a working knowledge of this policy.

4. Researches and responds to inquiries from the QA Unit.

5. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.

Program Integrity Unit Manager Responsibility

1. Participate in all QA question document review conversations.

2. Maintain a log of potential policy updates between process reviews for tracking purposes.

Adult Protective Services Responsibility

1. Notify QA and QI by email of process changes that may affect how QA Process Reviews are

completed.

a. It is encouraged to notify QA as topics arise.

### D. SAMPLE METHODOLOGY

Background

The QA Unit uses the statistically valid sampling methodology recommended by the Centers for The QA Unit uses the statistically valid sampling methodology recommended by the Centers for

Medicare and Medicaid Services (CMS). Raosoft’s Sample Size Calculator is used to determine statewide

sample sizes using the recommended 5% margin of error and 95% confidence level.

There are reviews in which entire population subject to review is too small to use only a sample of the

population. In these cases, the entire population is reviewed.

Procedure

Investigations

o Samples from each region will be investigations closed inconclusive, substantiated, and

unsubstantiated, and a sample of investigations closed No APS.

o The sample will be pulled from the three months after the PIP interventions are completed if

possible.

o Regional sample is based on the percentage of cases closed by unit during the time frame.

o The random sample of cases to be reviewed are then generated by usage of the RAND function

in Microsoft within the DataMart tool.

o This sampling process repeats for each Region and APS Central Intake.

Example of a sample calculation:

2,038 Investigations Closed No APS for Region X, during prior calendar year.

9,638 Investigations (inconclusive, substantiated, unsubstantiated) for Region X, during prior

calendar year.

2,038 entered into RaoSoft = 324 (statistically significant sample)

9,638 entered into RaoSoft = 370 (statistically significant sample)

Total investigations in prior three months = 2,169

Total Closed No APS in prior three months = 500

Unit A closed 5% of 2,169 Investigations and 7% of 500 Closed No APS.

o Sample size calculation size for Unit A:

o 370 x .05 = 19 Investigations,

o 324 x .07 = 22 Closed No APS

Unit B closed 1% of 2,169 Investigations and 2% of 500 Closed No APS.

o Sample size calculation size for Unit B:

o 370 x .01 = 4 Investigations,

o 324 x .02 = 6 Closed No APS

Unit C closed 7% of 2,169 Investigations and 3% of 500 Closed No APS.

o Sample size calculation size for Unit C:

o 370 x .07 = 26 Investigations,

o 324 x .03 = 10 Closed No APS

Intake

o APS Central Intake data sample Intake Screen-Out and Intake Screen-In.

Example of a sample calculation:

9,525 total screen in intakes processed during prior calendar year.

4,752 total screen out intakes processed during prior calendar year.

9,525 entered into RaoSoft = 370 (statistically significant sample).

4,752 entered into RaoSoft = 356 (statistically significant sample).

During the three months prior to the QA review start date, Central Intake created 2,578 screen

in intakes and 1,980 screen out intakes.

Intake Worker A created 3% of 2,578 screen in intakes and 2% of 1,980 screen out intakes

created during the three months prior to the QA review start date.

• Sample size calculation size for Intake Worker A:

o 370 x .03 = 11 screen in intakes,

o 356 x .02 = 7 screen out intakes

Intake Worker B created 6% of 2,578 screen in intakes and 5% of 1,980 screen out intakes created during the three months prior to the QA review start date.

• Sample size calculation size for Intake Worker B:

o 370 x .06 = 22 screen in intakes,

o 356 x .05 = 18 screen out intakes

Statewide

o 90-day reason code review

o Safety and Risk review

o Documentation Timeliness

o Statewide sample is stratified by cases closed by region within the population

Example of a sample calculation:

Total statewide investigations closed during prior calendar year with a 90-day reason code other than No Good Cause = 9,959

9,959 entered into RaoSoft for a statistically significant sample of 370

During the 2-month period prior to the QA review start date 1,850 investigations were closed with a 90-day reason code other than No Good Cause.

o Region A closed 480 or 25.9%

o Region B closed 732 or 39.6%

o Region C closed 638 or 34.5%

Sample size calculation for Region

A: 370 X .259 = 95.83 Sample size calculation for Region

B: 370 X .396 = 146.52 Sample size calculation for Region

C: 370 X .345 = 127.65

Region A would round to 96, Region B would round to 146, and Region C would round to 128.

The entrance documents will be sent to the program’s designees prior to the start of the process review as described in section labeled ‘Process Reviews’. The timeframe for the entrance communication may be adjusted based on program need.

QA Unit Manager Responsibility

1. Ensures sample methodology meets required standards.

2. Ensure training for new QA staff occurs.

3. Ensures QA staff demonstrate a working knowledge of this policy.

4. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.

5. Requests training or clarification from leadership as needed.

### E. PROCESS REVIEWS

Background

The QA Unit is responsible for determining whether specific proficiencies were met based on a

prescribed set of questions.

The process reviews discussed in this section are defined as: the entrance, the initial process review

work completed by QA, and the preliminary reporting. Process reviews are conducted remotely by the

ALTSA QA Unit and staff are not required to travel.

Each process review is assigned a QA Process Review Lead (QA Lead), who is responsible for ensuring

process review activities are completed. The QA Lead is considered the liaison and the SME for QA

activities for the areas to which they are assigned. For information about which QA Unit Member is

assigned as QA Lead for a specific area, please email APSQAUnit@dshs.wa.gov.

Procedure

ENTRANCE:

1. QA will e-mail entrance correspondence to the Designated Staff (DS) for the area being reviewed.

This will include pertinent information related to the process review, such as the name of the QA

Lead and an information sheet with pertinent dates and information for the review.

2. QA receives all correspondence via APSQAUnit@dshs.wa.gov.

3. The QA Lead will contact the Designated Staff to communicate any questions, concerns, or needs of

the unit prior to the start of the review.

4. The QA Lead is responsible for ensuring communication between the staff and QA occurs during the

review, as questions arise.

5. The QA Unit Manager or their designee will communicate with Policy, Training, QI, and other SMEs,

as needed to ensure the review is as accurate as possible, and new policies and procedures are

communicated to QA.

6. The QA Lead will track any issues with the review, with questions, or with question documents. This

information is gathered so that any issues are addressed at the next question document review

meeting to inform potential updates.

INITIAL PROCESS REVIEW WORK:

At the beginning of the review, the QA Lead will ensure the area subject to review is aware the review

has begun.

THE QA LEAD WILL:

1. Establish an open line of communication for the process review, and act as the primary point of

contact.

2. Notify the Central Intake or Regional Designated Staff (DS) and QI Lead of any immediate

remediation work necessary. Examples of immediate remediation work include sending a law

enforcement referral or updating person management with safety concerns.

3. Monitor the QA mailbox and respond to inquiries within 2 WD.

DURING THE PROCESS REVIEW, THE QA LEAD WILL:

1. Track all issues and work toward a resolution before QA begins the review.

2. Notify DS of any immediate remediation requests and the date they are due and follow up until all

remediation requests are addressed.

3. Add an RCN when immediate remediation action is required including the date the field was

notified.

4. Verify the action when the field notifies QA the immediate remediation action was taken and add

corresponding RCN.

5. Pull reports on a regular basis and identify issues which must be resolved. The QA Lead will manage

this process and ensure issues are found and corrected as soon as possible during the process

review.

QA Unit Manager Responsibility

1. Work with QA Staff during the process review to complete the review and address any concerns or

specific questions related to how to complete any part of the review.

2. Ensure training for new QA staff occurs.

3. Ensures QA staff demonstrate a working knowledge of this policy.

4. Requests training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Designate one specific contact person for information and actions related to the process review,

known as Designated Staff (DS).

2. When notified of immediate remediation action, ensure action is taken the same or next business

day.

3. Inform QA Lead when immediate remediation action is completed.

### F. INITIAL PROFICIENCY REPORTS

Background

At the completion of the review of records, initial proficiencies are sent to the QI unit and the

Designated Staff. These are the preliminary results prior to any changes made during the change request

process or at the Change Request Committee (CRC) meetings (refer to section labelled ‘Change

Requests’ for more information). These preliminary results are subject to change once change requests

are finalized.

Finalization of results in the QA Monitor tool occurs after the 30-day process described in the section

labeled ‘Thirty-Day Reviews’ is completed.

Procedure

1. The ALTSA QA MA will send preliminary reports by the date posted on the official QA Unit Schedule.

Reports are sent to the QA Unit Manager and the Program Integrity Unit Manager.

2. The QA Unit Manager or designee will forward the preliminary reports to the APS Director, APS

Deputy Director, APS Office Chiefs, and the ALTSA Senior QA Administrator.

3. The Program Integrity Unit Manager or designee will compile the results and provide a breakdown

of the data by Region and Unit. Results will include overview graphs, the proficiency reports, and the

QA Analysis Comments. Reports will be distributed to the RAs, DRAs, and PMs for the region or to

the Unit Manager for CI.

a. Email to RAs and PMs should include details of next steps, including when change requests are

due. Sample email template can be found in Appendix C.

b. The QIC enters Change Requests into the QA Monitor Tool by the due date identified on the

official QA Unit Schedule. To ensure timely receipt and review of all submitted change requests,

any requests must be submitted by APS staff to QI 5 WD prior to the due date on the schedule.

### G. REMEDIATION

Background

Remediation is the process of correcting an issue found during the QA review. Some findings relate to

health and safety, some issues could result in litigation, and other issues may result in monetary

penalties or federal payback of funds. These types of findings require the issue to be corrected. There

are times when remediation is not possible. QA question documents identify these questions by using

“Historical data, unable to remediate” as a remediation option.

Law enforcement referrals are required during intake and investigation activities. When there is a

finding related to a missing law enforcement referral, remediation is required to be completed the same

or next business day from the notification of the finding.

For any QA finding where an action was possible, QI staff will enter the appropriate remediation

response for each finding during the 30-day review cycle or indicate that remediation was not possible.

This input is required to allow the QA Monitor Tool to function properly at the end of each review year.

Procedure

1. Upon receipt of the initial proficiencies, QI and the DS for the region or central intake will review the

findings and determine remediation actions in cooperation with APS workers, supervisors, and

program managers as necessary.

2. The DS in partnership with the QI lead for the region or central intake will track and coordinate

remediation requests and ensure all remediation activities are completed as required.

3. QA will monitor APSQAUnit@dshs.wa.gov during the 30-day cycle.

4. QI will enter all remediations into QA Monitor during the 30-day review process.

QI Staff Responsibility

1. Review all QA findings and work with regional and central intake staff on potential remediation

actions.

2. In the QA Monitor Tool, QI will add a Review Cycle Note (RCN) to the process review to explain what

was done to remediate the finding, using the code “Action Taken” for the RCN type.

3. If a review requires multiple remediation actions, those actions may be documented within the

same RCN. It is not necessary to enter multiple RCNs within the same review. This does not apply for

RCNs with the code “Change Request”.

4. Notify QA via email when all remediation actions have been completed.

5. Ensure all remediation actions are completed on or before the required due date.

6. Notify APS leadership if deadlines are not being met.

APS Staff Responsibility

1. When notification of a finding is received, review the finding documentation to determine what

needs to be done. If you do not know what to do, contact QI for assistance.

2. Complete the appropriate remediation by the required due date.

3. E-mail QI that you have completed the remediation and what action you took to complete the

remediation. Do not send personal or confidential information via email. If you are not sure what to

say or what to send, contact QI.

4. If notified by QI staff that deadlines are not being met, APS leadership will work with regional or

intake staff to ensure priority is taken to address all remediation actions and communicate with the

QI staff.

QA Unit Manager Responsibility

1. Respond to inquiries and train staff on remediation processes and procedures.

2. Ensure training for new QA staff occurs.

3. Ensures QA staff demonstrate a working knowledge of this policy.

4. Request training or clarification from leadership as needed.

### H. CHANGE REQUESTS

Background

The purpose of the change request process is to allow staff the opportunity to provide additional

explanation or information so that QA findings can be reconsidered. When QA receives a change

request, the actions QA may take regarding the finding include:

• Overturn: When QA agrees with the information provided, they will overturn the finding.

• Uphold: When both QA and QI agree that the information provided does not support overturning

the finding, they will uphold, and QI will follow up to determine any necessary next steps.

• Change Request Committee: When QA and QI do not have enough information to overturn or to uphold the finding or determines that leadership needs to make the final determination, the QA Unit Manager will forward the finding to the Change Request Committee (CRC) to be considered.

Change requests must be submitted by 5:00 PM on the due date provided on the QA schedule. All

requests must be submitted as an RCN in the QA Monitor Tool using Contact Code “Change Request.” Email submissions and RCNs which do not include a correct contact code will not be considered. For

reviews completed in SharePoint forms, all requests will be entered into the specific form by the

designated due date and time.

Procedure

Requesting Changes to QA findings:

Prior to sending the change request, APS Designated Staff and QI will:

1. Review applicable QA question documents and instructions.

2. Review the policy in place at the time the investigation or intake work was completed.

3. Review historical Change Request Committee (CRC) decisions located on the QA SharePoint site.

a) If CRC has upheld a QA determination on the same issue, the request will not be forwarded to

CRC and the QA finding will be upheld.

b) If there has been a change to policy or a compelling reason exists for leadership to discuss the

issue again, QA will forward the request to CRC.

4. For investigation reviews, discuss the request with the Regional Administrator for the area who will

have the final say if the change request will be entered into the QA Monitor Tool.

5. For intake reviews, discuss the request with the Central Intake Unit Manager who will have the final

say if the change request will be entered into the QA Monitor Tool.

After determining the Change Request should be sent to QA:

1. QI will enter the RCN into the QA Monitor Tool.

2. Use the contact code “Change Request”. This code must be selected, or the request will not be

visible to QA and will not be considered.

3. All change requests must appear on the 2309 Change Request Report in ALTSA Reporting to be

considered. (Using the contact code “Change Request” accomplishes this).

4. The change request language should include the question and no response requested to be

changed, the reason why the change is requested, and policy language that supports the requested

change. The change request should not hold confidential information including AV or AP names,

dates of birth, or other identifying information.

5. If multiple questions and/or no responses within a review require a change request, enter a

separate change request RCN for each item.

THE QI UNIT WILL:

1. Ensure APS staff are aware of change request due dates and dates for when requests must be

received by the QI Unit for processing.

2. Review all change requests in collaboration with region or intake leadership in determining what will

be forwarded to QA.

3. Collaborate with QA Unit Manager to determine what will be upheld or overturned and which

requests will be sent to the CRC for consideration.

4. Report back to requestors to advise them of the outcome of their requests.

THE QA UNIT WILL:

1. Review and research each change request received considering the additional information.

2. Request additional information from appropriate SMEs (e.g., Training, Policy, Regional Staff, etc.) as

needed to clarify the issue.

3. Collaborate with the Program Integrity Unit Manager to determine what will be sent to CRC.

4. Forward requests that require a CRC decision to the committee prior to the CRC meeting.

5. QA Consultants will update findings in the QA Monitor Tool as directed by the CRC within 5 WD after

the CRC Meeting and will complete the 30-day reviews before the Final Exit Conference.

6. The ALTSA QA MA will e-mail updated reports to QA and QI within 2 WD when the proficiencies

have changed from the initial proficiencies or when required.

Change Request Committee (CRC) Responsibility

Purpose

To make the final determination as to whether to overturn or uphold QA findings. Each topic area or

finding will be discussed during the meeting and a determination will be made only by the voting

members as to the outcome of the QA finding(s).

Due to time constraints, countermeasures are not determined or discussed in detail at these meetings.

CHANGE REQUEST COMMITTEE MEETINGS:

1. CRC meetings are scheduled by QA and dates are published on the QA Schedule.

a. A scheduled CRC Meeting may only be changed with the approval of the APS Deputy Director.

b. When a voting member is unable to attend, they have the option to send a designee who will

stand in for them and act as a voting member.

c. It is preferred, but not required that all voting members attend. If one or two members are

unable to attend, the meeting may proceed without them.

2. CRC does not repeat change requests which have been decided in historical committee meetings

unless there is a compelling reason for them to hear the request again.

3. CRC may not hear change requests that have clear internal, state, or federal policy guidance. In

these cases, QA and QI will discuss these requests to determine the outcome.

THE CRC INCLUDES THE FOLLOWING VOTING MEMBERS:

1. APS Deputy Director

2. APS Office Chiefs who are not in charge of the area subject to review

3. Senior Policy Advisor

ALL NON-VOTING CRC ATTENDEES WILL SUPPORT THE CRC’S PURPOSE BY:

1. Allowing the process to flow without interruption.

2. Responding to questions from CRC voting members and others who require their expertise.

3. Responding to requests to provide evidence, policy guidance, best practice, or experience.

4. Refraining from voting or expressing a desired outcome.

5. Holding comments and questions about next steps, countermeasures, or follow-up.

6. Not forward invitations to CRC meetings.

a. For those whose attendance is required to provide expert opinion or information the CRC voting

members need, they will e-mail the meeting organizer to add the individual.

THE CRC WILL:

1. Review all change requests submitted and all supporting documentation.

2. Discuss each issue and ask questions that enable them to make an appropriate determination based

on the policies and procedures in place at the time the work was completed.

3. Vote to determine whether to uphold or overturn the QA finding.

a. If the vote is a tie, the APS Director or their designee will make the final decision.

b. When the CRC upholds the finding, APS must remediate the finding within 5 WD if remediation is possible.

c. When the CRC overturns the finding, QA will correct the review within 5 WD.

QA Unit Manager Responsibility

1. Provide clarification for QA findings and collaborate with QI to determine which requests are

overturned, which are upheld, and which are forwarded to CRC.

2. Only forward invitations to those whose attendance is required to provide expert opinion or

information the CRC voting members need.

3. Facilitate CRC meetings, maintain professionalism, and ensure the meeting stays on task.

4. Ensure training for new QA staff occurs.

5. Ensures QA staff demonstrate a working knowledge of this policy.

6. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.

2. Ensures QI staff demonstrate a working knowledge of this policy.

3. Collaborate with QA to determine which change requests will be overturned and which are

forwarded to CRC.

4. Ensure staff are provided the opportunity to present their request through their program’s

representative, their PM, or appropriate SMEs.

5. Only forward invitations to those whose attendance is required to provide expert opinion or

information the CRC voting members need.

6. Request training or clarification from leadership as needed.

### I. THIRTY-DAY REVIEWS

Background

Within the APS System, 30-day reviews are completed after the initial review when the initial review

included at least one finding (at least one question was answered with no). The purpose of the 30-day

reviews is to show all work has been finalized, all required remediation is complete, and the review

requires no further action.

Anyone entering QA reviews, including those individuals entering supervisory reviews or QI checks, must

also enter all 30-day reviews within 45 calendar days after the initial review is entered or before the QA

Monitor blackout period begins in December, whichever occurs first.

The QA Monitor blackout period occurs in December during which no reviews can be entered into the

system. During the QA Monitor blackout, the prior year is closed out and frozen, so any open reviews

create complications and unnecessary work for those using the system.

Procedure

THE QA UNIT WILL:

1. Complete 30-day reviews by the due date listed on the schedule.

a. When remediation is not possible and considered to be historical, QA will answer with N/A and choose the remediation “Historical data-unable to remediate”

b. When remediation has been completed, QA will answer Yes and choose the appropriate

remediation option.

2. The QA Lead will verify all reviews entered by QA are closed at the end of each review.

3. The QA Unit Manager or their designee will verify all reviews entered by anyone other than QA are

closed by the end of the year prior to the blackout period.

THE QI UNIT WILL:

1. Enter checks into the QA Monitor Tool periodically throughout the year to gauge impact and

effectiveness of PIP countermeasures or systemic changes.

2. Verify that all reviews entered are closed within 45 calendar days of the date the review was

entered, or before the QA Monitor Tool blackout dates, whichever comes first.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.

2. Ensures QA staff demonstrate a working knowledge of this policy.

3. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.

4. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.

2. Ensures QI staff demonstrate a working knowledge of this policy.

3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

4. Request training or clarification from leadership as needed.

### J. FINAL EXIT CONFERENCE AND PROFICIENCY REPORTS

Background

Once all change requests and 30-day reviews are completed, proficiencies are re-calculated, and a final

Exit Conference is held by QA to disseminate final QA results.

This process was initiated at the beginning of the 2024 QA cycle in response to feedback from staff that

initial results are not as helpful as final results.

Procedure

THE QA UNIT WILL:

1. The QA Lead will verify the review is completed and all reviews are closed in the QA Monitor Tool.

2. The ALTSA QA MA will send final proficiencies to the QA Unit Manager and Program Integrity Unit

Manager at least one (1) WD prior to the exit conference.

3. The QA Lead will coordinate and facilitate a Final Exit Conference which will include the following

information:

a. Information related to how the sample is chosen.

b. QA questions asked during the process review.

c. Review of findings and proficiencies achieved.

d. Highlights from the review, including how the change request process impacted proficiencies.

4. ALTSA QA will send an invitation to the Designated Staff and regional leadership. This meeting may

be forwarded to allow anyone with an interest in attending. Meetings are held remotely and

typically use Teams.

THE QI UNIT WILL:

1. Attend all Final Exit Conferences and will present information about upcoming Root Cause Analysis

meetings and next steps, including PIP due dates if a PIP is required.

2. Once completed, the QI Unit Manager or designee will distribute any updated proficiency reports to

RAs and PMs, if applicable.

QA Unit Manager Responsibility

1. Ensure training for new QA staff occurs.

2. Ensures QA staff demonstrate a working knowledge of this policy.

3. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.

2. Ensures QI staff demonstrate a working knowledge of this policy.

3. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Forward the exit conference meeting information to staff within the region or unit and encourage

attendance.

2. Review provided reports to understand information presented.

### K. PROFICIENCY IMPROVEMENT PLAN (PIP)

Background

Expected Proficiencies:

The expected proficiencies for each QA question take into consideration the minimum required

proficiency levels for the Centers for Medicaid and Medicare Services (CMS) waivers, any areas outlined

on the ALTSA strategic plan, and the required proficiencies required by external auditors. Some

questions require a higher proficiency level because of expectations by CMS, an external auditor, or

executive leadership. The APS Director makes the final determination as to APS expected proficiencies.

Proficiency Improvement Plans:

A Proficiency Improvement Plan (PIP) outlines a plan for addressing QA questions that did not meet the

required proficiency.

The action required for PIP development is based on the findings of the process review once all change

requests are considered and the final proficiency results are distributed.

Action is required for PIP development. A PIP is not required for the current QA Unit review cycle:

a. When required proficiency of 86% is reached on all QA questions.

b. When the APS Director has requested APS staff and the PIPA unit to develop a PIP on a

QA question that does not meet required or expected proficiency at a statewide level.

Procedure

1. PIP development and completion is the responsibility of the QIC in partnership with APS staff.

a. The QA Unit is not involved in PIP development activities and does not direct the work that

needs to be accomplished to complete the PIP.

b. The use of Lean and Continuous Improvement tools is encouraged. Information and tools for

ALTSA’s Lean program can be found here.

c. Any units or staff assigned a task on the PIP must be notified of the assignment before the PIP is signed by the APS Deputy Director.

2. The completed PIP must be submitted to the APS Deputy Director for final approval within 30 WD

after the regional final report. This due date is included on the published QA Schedule.

3. A copy of the approved PIP must be saved to QIC Central in both PDF and Word formats (Word is

used as a working document) once it is signed by the APS Deputy Director.

4. PIP Monitoring:

a. The QI Lead will send the final signed PIP to any staff assigned a task.

i. The QI Lead tracks due dates on the final approved PIP to monitor for completion.

ii. The QI Lead will notify the Program Integrity Unit Manager if there are any potential

barriers to completing interventions within the defined timelines.

iii. The QI Lead provides written monitoring updates to leadership staff on a quarterly basis.

b. QI Unit Manager provides APS leadership with status reports as requested.

c. If PIP interventions or due dates change, the QI Lead will update the working version.

d. There should only be one working PIP at any given time for a process review. If the previous PIP is not yet completed by the next process review, the PIP should be closed with notation that

interventions can be found on current PIP.

e. QI will make every attempt to utilize the same Sample Methodology process when completing

monitoring checks to determine if PIP interventions are working.

QA Unit Manager Responsibility

1. Train new staff and ensure they can demonstrate they understand this procedure.

2. Request training or clarification from leadership as needed.

Program Integrity Unit Manager Responsibility

1. Ensure training for new QI staff occurs.

2. Ensures QI staff demonstrate a working knowledge of this policy.

3. Conduct periodic reviews of this procedure to ensure staff are following it correctly.

4. Request training or clarification from leadership as needed.

Adult Protective Services Responsibility

1. Ensure robust participation in the data gathering and root cause analysis process by regional

leadership, supervisors, and workers.

2. Encourage curiosity in examining systems.

3. Actively demonstrate shifting attitudes from blame to accountability and encouraging examination

of process within and outside of the individual’s control.

4. Allow space within monthly regional leadership meetings to discuss root cause analysis process,

interventions, and data from monitoring of the interventions.

5. Regional leadership/Central Intake Unit Manager approves and signs the written PIP before

forwarding to APS Deputy Director.

6. Implement identified interventions.

7. Ensure information on the process, interventions, and monitoring are made available to APS staff by

way of newsletters, staff meetings, and other appropriate communications.

### L. RECORD RETENTION

Background

Records are retained for historical information, data, and public disclosure purposes. For APS records

retention information, please visit Policy Tech.

This section will provide an overview of how the QA Unit retains records of process reviews completed.

Procedure

1. QA Reviews are performed in the QA Monitor application or in Microsoft Forms.

2. If desired, QA unit members may use paper checklists or electronic checklists while completing the

process review to ensure all process review questions are answered and input into the QA Monitor Tool correctly.

3. Once the review is completed, the review must be entered into the QA Monitoring Tool or Microsoft

Forms Review as soon as possible. All information pertinent to the findings must be included in the

analysis comments in the QA Monitoring Tool or Microsoft Forms Review.

4. QA unit members may retain paper or electronic checklists only until the 30-day reviews are

completed and the full review process is closed.

5. All paper documents related to the QA process review must be shredded in confidential shredding

to avoid the release of any alleged victim names or other protected information.

6. All electronic documents created on OneNote, on the computer’s desktop, or using any other

programs created by the QA Consultant will be deleted once the 30-day reviews are completed. The

QA Monitor Tool is the final and complete record for all QA reviews.

7. Records will be retained in the QA Monitor tool for six (6) years, after which, the records will be

purged, unless there is a reason for which the record must be retained.

a. The QA Unit Manager will send a notification annually to Central Files prior to the scheduled

record purge to determine which records may not be purged from the system and the reason

the record may not be purged.

8. Reviews created utilizing Microsoft Forms will be downloaded to Excel and saved in the shared Q

drive for six (6) years, after which, the records will be purged, unless there is a reason for which the

record must be retained.

QA Unit Manager Responsibility

1. Request training or clarification from leadership as needed.

### M. FINAL REPORTS

Background

The QA Lead creates a report for each region or central intake following the completion of their review

cycle.

The QA Unit Manager develops an Annual Statewide Final Report to publish results of the cumulative QA

process review cycle for APS. This report outlines the results for each review type on a statewide basis

and compares any historical data for the reader’s analysis.

The Program Integrity Unit Manager develops an Annual Report to publish information about the status

and effectiveness of all Quality Improvement interventions implemented in response to QA Process

Reviews.

Procedure

THE QA LEAD WILL:

1. Create the report based on the final proficiencies for Central Intake or the region.

2. Provide the report to the QA Unit Manager two (2) WD prior to the due date for approval and

signature.

3. Send the signed report to Central Intake Unit Manager or regional leadership, and APS leadership on the due date.

THE QA UNIT MANAGER WILL:

1. Review the Central Intake and Regional Final Reports for accuracy.

2. Once the Central Intake and Regional Final Report is completed and verified to be accurate, signs

the report.

3. Create and post the statewide final report annually and seeks clarification and information from

programs as needed to clarify results or explain circumstances that may be needed to properly

analyze the data.

4. Publish the statewide final report in an MB and on the QA SharePoint site once the report is

complete.

THE PROGRAM INTEGRITY UNIT MANAGER WILL:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall

proficiencies.

2. Post the report on the QI SharePoint site.

QA Unit Manager Responsibility

1. Creates and distributes any required final reports.

2. Requests training or clarification from leadership as needed.

ALTSA QA Senior Administrator Responsibility

1. Review and approve the statewide final report prior to presentation to APS Leadership for review,

approval, and distribution.

The Program Integrity Unit Manager will:

1. Create and post the report annually to demonstrate the effectiveness of PIP interventions on overall

proficiencies.

a. Program Integrity Unit Manager will send draft information to the process review QI Lead to

verify information, including data and status of interventions.

2. Post the report on the SharePoint site.

Adult Protective Services Leadership will:

1. Read the QA and QI final reports.

2. Ensure information from the QA and QI reports regarding process, interventions, and monitoring are

made available to APS staff by way of newsletters, staff meetings, and other appropriate communications.

## PART II: QUALITY CHECKS

The QA checks completed by Quality Improvement Coordinators (QIC) are very important because they

ensure staff are protecting our vulnerable adults by following policy, procedure, and conducting

thorough investigations. QIC QA reviews help identify training and policy concerns. The QIC reviews QA

questions ensuring the health and welfare of the alleged victim. As a result, the QIC role is a critical part

of the foundation for overall APS quality compliance and consistency.

a. Reviews are completed by QICs or their designee.

b. QA reviews and PIP checks are performed for new and experienced staff according to the

direction of APS leadership.

c. All reviews are completed within the QA Monitor Tool, in Microsoft Forms, or tracked in Excel.

d. All remediation activities must be completed, and the review cycle closed within 30 working

days of initial review.

e. Review data will be saved and reviewed from year to year for quality improvement purposes.

Review activities are performed throughout the entire calendar year.

## PART III: INTERRATER RELIABILITY

Purpose: To ensure consistency within the APS QA review process.

Prior to beginning the review cycle,

• The QA/QI team will complete three reviews together in training QA Monitor discussing each

question and identifying what to look for.

• After that process, three intakes/investigations of each type (screen in, screen out,

investigation, closed No APS) will be selected for independent practice review. Each reviewer

will independently complete 3 reviews in training QA monitor. The other reviewer(s) and the QA

Unit Manager will review those answers (Yes, No, or N/A) and any no responses given and

compare for accuracy using the check spreadsheet. Any comments will also be reviewed to

ensure accuracy and helpfulness. The group will return back together to discuss each review and

the individual findings.

• Any discrepancies will be reviewed and verified within the How to Review guide.

During the compliance review cycle

• The QA unit manager will review 10% of each reviewer’s cases for accuracy. Reviews will be

completed on the check spreadsheet and shared with each reviewer.

• Each reviewer will select 2-3 reviews per week for peer review. Reviews will be completed on

the check spreadsheet and shared with each reviewer.

• Any peer review will be completed with feedback provided at least 3 days before the end of the

review cycle to ensure any necessary changes are made before providing QA data to central

intake or the region.

Throughout the cycle, the reviewers are in communication with each other when questions arise on how

to review situations which are not outlined in the How to Review guide or the training videos. If not in

agreement, a discussion is held with the QA Unit Manager who will review the situation and applicable

policy in addition to prior guidance. For questions if policy was followed that cannot be identified

through review of Policy Tech guidance or previous decisions from executive leadership, the Senior

Policy Advisor will be consulted for the final decision.

Check spreadsheets will be maintained in the APS QA Q: drive.

During the reviewer’s probationary period,

• Complete the QA review training videos.

• Shadow a minimum of two other reviewers for 5 reviews each.

• The trainee reviewer will look at 10 historical reviews, comparing the historical reviewer’s

answers and comments to information found in TIVA2 and the How to Review guide. The

trainee reviewer will outline thoughts and questions to review with the QA Unit Manager.

• The trainee reviewer will complete 10 reviews in training QA monitor with review by the QA

Unit Manager.

• This process will be completed before beginning QA reviews in production QA Monitor.

## PART IV: APPENDICES

### A. GLOSSARY OF TERMS

Agency – State agency

Change Request Committee – means QA and QI do not have sufficient information to determine if a

change request should be upheld or overturned and determines APS leadership needs to make the

final determination.

Department – This term refers to the Washington state Department of Social and Health Services

(DSHS).

Designated Staff – Refers to the regional or Central Intake point of contact for QA/QA process.

Finding – A term used to describe an identified gap between policy guidance and what was found

during a QA process review.

Overturn – means QA agrees with the information provided within a change request and overturns

the process review finding.

Population –The entire population subject to review.

Unit Leadership – means the individuals responsible for the activities of a designated unit. This can

include Unit Managers, Program Managers, and Regional Administrators.

Uphold – means QA and QI agree that the information provided in the submitted change request

does not support overturning the finding, and the finding will remain in place.

Working days (business days) – defined as Monday through Friday, excluding federal and state

holidays.

### B. ACRONYM LIST

ALTSA Aging and Long-Term Support Administration

CMS Center for Medicare and Medicaid Services

CRC Change Request Committee

DRA Deputy Regional Administrator

DS Designated Staff

DSHS Department of Social and Health Services

MA Management Analyst

MB Management Bulletin

MSD Management Service Division

OAS Office of the Assistant Secretary

PIP Proficiency Improvement Plan

PM Program Manager

QA Quality Assurance

QI Quality Improvement

QIC Quality Improvement Coordinator

QMS Quality Management System

RA Regional Administrator

RCN Review Cycle Note

RCW Revised Code of Washington

SHPC Social and Health Program Consultants

SME Subject Matter Expert

SPA State Plan Amendments

TIVA Tracking Incidents for Vulnerable Adults

WAC Washington Administrative Code

WD Working Day

### C. SAMPLE QA PROCESS REVIEW RESULT EMAIL TEMPLATE

Region X APS HQ QA Process Review has been completed and the following reports are attached to this

email:

▪ The QA Review Data workbook includes the 2307 Proficiency with Details report, the data

broken down by supervisor, case manager, a heatmap by offices and the 2303 Questions

Requiring Action Report broken down by supervisor.

▪ The Findings and Analysis workbook provides a Data Analysis report with the questions,

findings and analysis comments for each review that received a finding, the 2310 Analysis

Comment Report, the 2303 Questions Requiring Action Report.

Also attached is the Remediation and Change Request Process guide, 2023 Remediations for APS

Investigation guide and the Region X tracker.

What’s Next?:

▪ Region X’s 30-day remediation timeline is XXXX –XXXXX. Change Requests will need to be

submitted by close of business on XXXXX (via QA Monitor).

▪ Most remediation items will be considered “Historical Data,” which require no physical action;

please encourage supervisors to facilitate learning opportunities with their staff regarding these

items. Remediation completed by region must be documented in a Review Cycle Note (RCN)

when an action is completed to remediate findings. Using the “Action Taken” drop down, the

Review Cycle Note (RCN) must include information about how the finding(s) was remediated.

## D. RESOURCES AND FORMS

Background

The QA Unit has transitioned to using a QA SharePoint as the primary means of communication with APS

staff, Policy, Training, and anyone at APS interested in QA activities.

Members of the QA Unit have access to the QA Unit’s internal SharePoint site. This site is only accessible

to the QA Unit and other leadership staff as required. The site provides the tools, templates, and

information needed to complete process reviews.

Procedure

Process Review Areas and Programs

1. Investigation

a. QA reviews the following areas:

i. Timeliness

ii. Documentation

iii. AV Interview

iv. AP Interview

v. Collaterals

vi. Decision Making Ability Screening

vii. Law Enforcement Referrals

viii. Outcome Reports

ix. Vulnerable Adult Status

x. Allegations

xi. Finding

xii. Protective Services

xiii. Supervisor Actions

2. Closed No APS

a. QA reviews the following areas:

i. Finding

ii. Law Enforcement Referrals

iii. Outcome Reports

3. Intake Screen In

a. QA reviews the following areas:

i. Timeliness

ii. VA Status

iii. Safety

iv. Referrals

v. Screen In accuracy

vi. Allegations

vii. Intake Priority

4. Intake Screen Out

a. QA reviews the following areas:

i. Timeliness

ii. VA Status iii. Referrals iv. Screen out reason

5. 90-Day Reason Code

a. QA reviews the following areas:

i. Reason code documentation

6. Safety and Risk Screening (Biennial)

a. QA reviews the following areas:

i. Screening evidence

ii. Staffing

iii. Timeliness

7. Documentation Timeliness (Biennial)

a. QA reviews the following areas:

i. Case notes

ii. File Uploads

Additional Information

a. Only closed investigations or completed intakes will be reviewed.

b. Additional reviews may be conducted as requested by executive leadership. Reviews are subject to change by leadership and a schedule is posted each year to clarify which reviews will occur that year and when during that year those reviews will occur.

QA Unit Manager Responsibility

1. Train new staff and ensure they can demonstrate they understand this procedure.

2. Conducts supervisory reviews of QA staff work to ensure policies and procedures are followed.

3. Request training or clarification from leadership as needed.